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PUBLIC HEALTH NURSING

VOL. 43, NO. 1 JANUARY 1951

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PUBLIC HEALTH NURSING

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NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

2 Park Avenue, New York 16, N. Y.

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The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine, PUBLIC HEALTH NURSING, and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members. Its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

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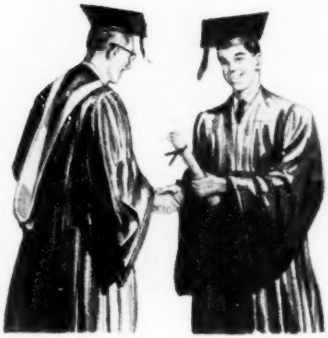

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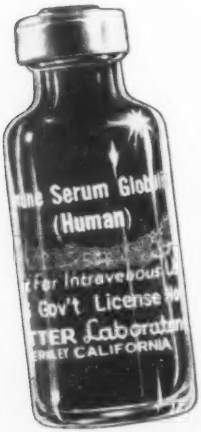

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PUBLIC HEALTH NURSING

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Your Part in Reorganization

"WHY SHOULD I continue my NOPHN membership now that we're all reorganizing?" one of our individual members asked in a recent letter. The question really rocked us back on our heels. Could any member feel that she wasn't needed with so many extra jobs to be done this year?

But then we got to thinking . . . maybe there are other members who are asking this same question . . . maybe it isn't entirely clear to some how much must be done before work on our new organizational structure is completed . . . maybe we need to remind all individual members, and all potential members, that there never was a year when NOPHN needed them more—their opinions and ideas as well as their dues.

True, all six national organizations have voted for a two-organization structure, but there is still the final blueprint to complete. Nursing, luckily, has no dictator to say, "*This is the way it will be.*" The job will be done democratically, as we all want it to be done, and that means that time and money must be allowed for consideration, discussion, amalgamation of opinion, and final vote.

Each national organization has its own committee working on structure. Representatives of these committees make up the overall Joint Coordinating Committee on Structure. All of these committees are very much on the job, eager to finish as quickly as the job can be done well. But there are scores of points to be discussed and settled: objectives, functions, membership, meetings, voting, sections, directors, officers, committees, duties, powers, dues, legal technicalities, state organizations, and local organizations—lots of help from all members will be needed in planning for these! We stop for breath, yet that's not the whole list, by any manner of means. And after the design is finished, arrangements must be made for the orderly transfer of programs of work. It will take the hardest kind of work to complete all of this by the 1952 biennial convention when bylaws must be presented to the memberships of all the merging organizations for vote. After that the actual transition from the present organizations to the two new organizations will take place. Fortunately, many activities are already being carried forward jointly so that the two new organizations can begin to function that much more easily.

It is obvious that during the two years ahead, work on reorganization will be one of NOPHN's most important jobs. Meanwhile, the job to be done nationally for public health nursing and all of nursing is getting bigger all the time and is particularly critical now with the war emergency.

With the full support and active interest of an enthusiastic membership, NOPHN can move smoothly and strongly into the new structure and, at the same time, continue full speed ahead with the essential activities that are part of its regular program and that are so vital to all in public health nursing. But the backing of an interested and increasing membership is a *must*. To keep public health nursing strong on the national front and to take it into the new structure in a vigorous

healthy state, NOPHN must be strong and only its members can make it so because *the members are* NOPHN.

The great majority of NOPHN's members recognize this, of course, and know the importance of each individual member to the work of her national organization. Best evidence of this recognition is the ready response there has been to our president's request for early renewal of individual membership for 1951. At the end of December about half of our 1950 members had paid their dues for 1951. This is a fine show of cooperation and greatly appreciated.

Perhaps, then, one could say that this reminder is not really necessary. But if a reminder *is* needed, certainly now is the time for it, rather than later. Will you help pass the word? If you have already sent your own 1951 dues to NOPHN headquarters, will you talk with your friends and coworkers about NOPHN membership? Let's all help assure that NOPHN is the strong organization we all need it to be this year.

The March of Dimes

The March of Dimes has marched right on across the American scene and has found a warm place in the hearts of most of our people. The collection of dimes—and quarters and dollars—during the period of the last two weeks in January carries with it special significance for each person or group that contributes. Many give because someone near and dear has been afflicted with polio. Others contribute to help victims who made headlines in the newspapers during the year. A small number realize the increasing cost of pure research and give with this purpose in mind.

Nursing has a true interest in the March of Dimes, sharing as it does in the giving and in the programs supported by the money so collected. We are extremely proud of the work of the Joint Orthopedic Nursing Advisory Service which annually receives a grant from the National Foundation for Infantile Paralysis. JONAS has just gone through one of its busiest years. Fortunately, the NFIP made funds available so that additional personnel were employed to aid in the program of preparing nurses to care for polio patients in their own communities. Institutes and workshops for nurses are among the main activities of the JONAS staff. More than 2,500 nurses attended three- to five-day courses directed by JONAS consultants in the last year.

Dramatic and dreadful as most severe epidemics are, the acute period is usually comparatively short. The long-time care needed by a patient stricken with polio, especially for the long rehabilitative stages, makes many drains upon the family, the community, and professional personnel. Many patients need care and assistance of various kinds for several years. In 1949 a census of polio patients in respirators was taken and this census was repeated this year. It was found that 200 more patients were in respirators in 1950 than in 1949, the total number being just over a thousand.

Special respirator centers are being established in various parts of the country. Patients from areas where there are few facilities are to be brought to the center so that no small community is made responsible for caring for just one or two patients in respirators. The large number of patients who must live for months or possibly years in respirators makes further research in this entire field extremely important. These respirator centers are to be teaching centers where nurses as well as other professional personnel will gain experience. Unfortunately, there exists a dearth of prepared instructors, which may prove a handicap in furthering this program.

One thing is clear: There still is a big job to be done before polio can be conquered. Fortunately, each one can have a share in doing this job. One simple way is to join the March of Dimes.

Priorities in Public Health Nursing Education

FROM THE TIME of its founding, the National Organization for Public Health Nursing has been concerned with the education of public health nurses and for many years has supported an active committee on education whose influence has been far-reaching. Composed of members representative of both education and service, this committee has developed current educational standards and stimulated the wise use of facilities in order that public health nurses might have preparation adequate to meet the needs of their communities. Education has always been viewed as a means to better service, not as an end in itself.

Although we hear much more these days about nurse shortages in public health nursing as well as in hospital services, the demand in this country for well prepared public health nurses has constantly exceeded the supply; and in spite of our best efforts we find only about one third of our public health nurses with adequate preparation for public health nursing. This situation is the more critical because the present worldwide program for the opening up of health services in underdeveloped and undeveloped countries demands some well prepared public health nurses from our country, which adds to our own shortages.

Moreover, the remedy for this situation does not seem to lie in the development of more of these graduate nurse first level programs, since over the years all of the accredited university programs have seldom been filled to capacity, and qualified faculty members are difficult to secure in numbers sufficient to staff the already existing programs. Furthermore, when such programs are carefully examined one finds that much time is spent in supplementing inadequate basic nursing preparation preliminary to the study of public health nursing and that this pattern of education is so time-consuming and hence so costly that further expansion is not warranted.

Attention has turned, therefore, to the university basic degree programs which have been developing in heartening numbers during the last few years. Although many of them need much strengthening their graduates in general are showing the value of good basic preparation in the biological and social sciences and in the various nursing specialties through their understanding of behavior, their grasp of teaching content, and their ability to give comprehensive nursing care. But to produce this type of basic preparation every faculty member must understand and consistently teach "total nursing care" and "community nursing." Each one must be able to point out to the students possibilities for nursing care before and after hospitalization and for the use of community resources to meet other health and social needs of the patient and his family. These understandings must be enlarged and deepened as the students progress through their years of university study. For the present, then, this need poses the problem of supplementing faculty education in many instances and it must be recognized when priorities are established.

IT IS INTERESTING to note that because so much of the content is integrated throughout the curriculum the university basic program is able to prepare the student to function after graduation as a staff public health nurse in a shorter total period of time than is required by the other method. Moreover, the inclusion of public health nursing in the basic degree program in turn broadens the student's concept of total nursing, and it is our hope that through this increasing group of nurses we may eventually see real "community nursing" come into being.

Hence, to members of the NOPHN Education Committee who survey and try to reconcile the needs and the resources of our profession, the university basic degree program is welcomed as one which will eventu-

ally bring to public health nursing much better prepared staff nurses and many more of them. It seems our one best chance of closing that great and rapidly increasing gap between supply of and demand for qualified public health nurse personnel.

The Education Committee has always established priorities, restating them at intervals as conditions change. A new statement on priorities in public health nursing education appears in this issue (page 34). This statement indicates the measures that must be taken if the available facilities are to be utilized to produce the best results in the shortest time.

To each of us, in our own way, will come ample opportunity to support the National Organization for Public Health Nursing in its efforts to develop these priorities into a practical working pattern. If we disagree with them, after trying them, we must let the committee know, for standards and facilities and priorities are not fixed, but change as knowledge and resources develop. As individuals, we tend to forget that, just as we each need the NOPHN in order to accomplish each day's work, so NOPHN (which is really all of us working together) needs active participation from each of us in order to accomplish its day's work. The Education Committee asks that we read this statement of principles thoughtfully and then consider how best each of us can help to put them into practice in her own community.

KATHARINE FAVILLE, R.N., *Chairman*
NOPHN Education Committee, 1946-1950

Committee on Structure

PLANNING AND ACTIVITY in relation to the structural reorganization have gone on continuously since the Biennial Convention. The appointment of new structure committees and the establishment of the Joint Coordinating Committee on Structure give added impetus to all the work that still must be carried out before the goal of reorganization is fully achieved.

The chairman of the NOPHN Committee on Structure is Ruth B. Freeman, recently of the American National Red Cross and now associate professor and head of the Division of Public Health Nursing, School of Hygiene and Public Health, Johns Hopkins University. The other members of the committee are Alma C. Haupt, director of the Nursing Bureau, Metropolitan Life Insurance Company; Ruth W. Hubbard, executive director, Visiting Nurse Society, Philadelphia; Evelyn Kidneigh, director, Division of Public Health Nursing, Utah State Department of Health; Mrs. Gretchen Osgood, staff nurse, Nashoba Associated Boards of Health, Ayer, Massachusetts; Mrs. Philip A. Salmon, chairman, NOPHN Board and Committee Members Section; Marion W. Sheahan, director of programs, National Committee for the Improvement of Nursing Services; Mrs. Mabel K. Staupers, president of NACGN; and Dorothy Wilson, director, Visiting Nurse Association, New Haven, Connecticut.

Members of the Committee on Structure and the Coordinating Committee represent geographic sections and a variety of special interests, including the field nurse.

The NOPHN committee held its first meeting on December 15. Highlights will be reported in the next issue. The Joint Coordinating Committee on Structure, of which Pearl McIver is chairman, has met several times during the fall and winter. At the November meeting it was decided to release frequent reports to the national nursing magazines. Plans for securing reprints of articles on structure from *The American Journal of Nursing* and PUBLIC HEALTH NURSING will be announced soon.

Common Ground for Common Objectives in Public Health

LEONARD W. MAYO

Teamwork is essential

CLIMB TO THE TOP of the tallest building in your town or the highest hill in your county, or look down through your mind's eye on the total area in which you work. Stretching away, below and beyond you, there is a portion of the earth inhabited by people. Here in a literal sense is your local "common ground" for common objectives!

Since the dawn of time it has been the driving aim of man to increase the livability of this planet we call our world. He has sought to conquer, control, and direct the forces of nature to this end and the fact that he has been able to do so to the degree he has, is little short of miraculous. Perhaps we have gone about as far as we safely can in that single direction, for unless man learns soon to conquer and control himself, the forces of nature he is now harnessing may turn upon him one day and snuff out his life. Indeed, many thoughtful people have warned us that the discoveries of physical science could destroy us unless the social sciences catch up with this cosmic stuff we call atomic energy.

The tense and continuing struggle between the forces that build and conserve and those that destroy and lay waste is, of course, inherent in the universe and hence in man himself. We know of no way as yet to prevent the ultimate disintegration of the physical body. But we have evidence that an indomitable and unquenchable human spirit is indestructible. Anything we do, therefore, as intelligent human beings, as citizens, or as members of a profession to aid man in his struggle to understand and control himself and nurture his spirit is a contribution of profound importance. To add something to the total well-being of man is no simple task in these days. Indeed it never was, but we are beginning now to understand just how superficial some of our past efforts have been.

The ultimate and broad aim of public health is to help in substantially increasing, enlarging, and improving the total well-being of man, to the end that he may eventually not only survive in the physical sense but prevail in the spiritual. To fulfill such a mission, even to a degree, all who labor under the public health banner must see clearly the common ground on which they work. If they do their common objectives, both specific and broad, will be evident.

In one sense what I am discussing is "geotechnics," the word that Patrick Geddes used over thirty years ago and of which Benton Mackaye writes in his article, "Growth of a New Science," in the October issue of *The Survey*. "Geotechnics is the applied science of making the earth more habitable," according to Mackaye's interpretation. In the broad sense geotechnics is a better term than "community organization" as used in public health and social work; particularly if one is willing to accept the prior concept that the important thing about the earth is its people.

The common ground then in public health

Mr. Mayo is director of the Association for the Aid of Crippled Children and chairman of the Commission on Chronic Illness.

is philosophic and scientific, practical and real. It is the sense of our common purpose and destiny, the knowledge we possess about people, and it is that portion of the earth, that is, the community, where we and our colleagues labor.

This, you may say, is taking a very long way around to reach the obvious. As a matter of fact, these things are not obvious to a good many professional people. If they were I am confident many of them would behave differently. Individuals and groups in any field of endeavor do not work together toward common goals automatically or simply because they are told it is the thing to do. The laws of learning apply in community organization for public health as well as in other places and situations. People must become so thoroughly a part of this thing we call cooperative endeavor or teamwork that they will carry it on with the same commitment and zest as any other essential part of their jobs.

The team approach will not become accepted practice until the layman and professional worker alike fully understand and appreciate the underlying reason and necessity for it. The reason, of course, is inherent in the common ground on which we operate, as pointed out earlier, and in the common objectives we recognize. Even more specifically, perhaps, the reason lies in the nature of our common task. In public health we are dealing with wholes—the whole community, the whole person, the whole disease or condition, the whole problem. This being so we can hardly treat or make effective impact on a *whole* through an approach that is *partial*.

Again we must seek the philosophical basis of the common ground on which we work, for thus far in our history scientific knowledge alone has not sufficed. To be sure, the facts about the whole derive from science, but guidance as to what we should do for the common good with the facts thus gained lies largely in the realm of philosophy. In the spirit of both the scientist and the philosopher, then, let us look at some of the common objectives faced by public health nurses, physicians, social workers, teachers, research staff, sanitation engineers, administrators, board members, and other members of the public health team.

INTEGRATION

The first is the development of a unified and positive health program for the community. We need a unified and integrated program to offset the present unfortunate tendency, if not trend, toward single, isolated, and unrelated programs. Someday we shall realize that the heart, the lungs, the limb stricken with polio, the member affected by cancer, and the emotions are all parts of a whole.

I am not sure what this realization, when it comes, will mean to the present structure and constellation of health and welfare agencies. I am inclined to think that is relatively unimportant. But it is important that the patient, that is, the community, shall benefit by an approach that is based on a concept of wholeness and unity; a concept which must be held and a unity that must be consummated first in the minds of individual staff members before they can be expressed in practice.

A positive health program, moreover, is more than the absence of disease. It is the presence of well-being. It is frequently difficult for those nurses and physicians who must live with illness to catch the spirit of health as a positive and dynamic force. The story is told of a young woman who was asked whether the department store in which she worked gave good service. She replied that it did not and then added casually that she worked in the complaint bureau. Her entire view obviously was dominated by what she saw and heard daily in a portion of the store that was hardly typical of the entire enterprise. To offset such a danger, to insure the community against blind spots, partial knowledge, and an insufficient number and variety of skills, we need the whole team in public health functioning positively and in unison.

UTILIZING NEW DISCOVERIES

A second common objective is that of making the most of recent developments in medical science. This era has quite properly been called "The Golden Age in Medicine." The

last forty-five years of intensive research have produced knowledge which has virtually conquered yellow fever, typhoid fever, tuberculosis, and the communicable diseases of childhood. Modern times have produced fundamental and revolutionary advances, some of which were recorded in the *New York Herald Tribune* of January 1, 1950, by Lester Grant, special writer on medical affairs, who listed the following:

Discovery of the antibiotics.

Development of biochemical research making possible the fractionation of blood plasma and the provision of serum albumin for shock.

The identification of vitamins.

The extended use of hormones leading to the development of ACTH and cortisone.

The use of liver extract in combating pernicious anemia.

Refinement of surgical and research technics.

Development of extensive anti-malarial agents.

The use of radium.

There might well be added to these the new concept of total rehabilitation of the handicapped as a striking example of basic team operation at its best.

If these and other developments are to be used to the full for the benefit of the individual, extensive health education of high quality must be carried on through the channels of public health agencies. In view of this it is unfortunate that for years many municipalities and counties have either omitted provisions for health education from the budget of their health departments entirely or allocated such relatively small amounts as to render that portion of the program impotent.

We have at our fingertips discoveries both actual and potential almost as miraculous as the legendary fountain of youth, but unless we inform and educate people where to find them and how to use them we are missing a golden opportunity to reduce suffering and death and at the same time save the taxpayer substantial sums. The health agency, moreover, must have a high grade of personnel if it is to utilize these new medical discoveries. Scores of voluntary and governmental health agencies accomplish a great deal in spite of low budgets and consequent understaffing. In town after town, however, the health departments are weak, and all too many counties in the nation have only one parttime health officer. In a shocking number of counties, furthermore, not a single health officer is to be found. Such a state of affairs should challenge every layman and professional worker in such areas. There can be no teamwork without the key "players" and no substantial gains toward essential objectives without at least a minimum of qualified personnel, including public health nurses who are needed to convey and interpret our new knowledge to the family unit.

JOINT PLANNING

A third common objective, implied but not necessarily covered in the two foregoing, is that of joint planning by the several agencies represented on the public health team. In rural areas and small towns this may seem on the surface to be an almost academic matter because of the comparative paucity of facilities and personnel. As a matter of fact, however, the principle obtains no matter how many or how few individuals and agencies are involved. In the September 1950 issue of the *American Journal of Public Health*, Dr. Marcus Kogel, commissioner of hospitals in New York City, urges that the hospital administrator and the public health officer no longer ignore the fact that their respective areas of jurisdiction are drawing closer with every new development in medicine and public health. This is a specific case in point.

Until and unless there is better and more extensive joint planning among members of the public health team on a local, district, and regional basis, we shall be stymied in the conquest of those diseases and conditions which still threaten our communities. We shall fail, furthermore, to make full use of such sound methods as multiphasic screening and other forms of casefinding, and lag in the full development of such basic procedures as registration and reporting.

When we see clearly the common ground on which we work for the common good in public health and view from that vantage

(Continued on page 16)

Nursing Opportunities in Medical Care Insurance

MARGARET C. KLEM

Publicity and demonstration are needed to promote understanding of the value of nursing benefits in medical care plans

ADVOCATES OF MEDICAL care insurance have two major purposes in mind: first, to budget the otherwise unpredictable cost of illness by applying the insurance principle and, second, to make medical services more readily available and thereby improve the nation's health. If these objectives are to be met nursing services must be included among benefits provided, for nursing, like other medical services, is often expensive when paid for on a fee-for-service basis. Private expenditures in the United States for professional and practical nurses and for midwives amount to approximately $200,000,000 a year—almost 3 percent of the total family expenditures for medical care. Various surveys show that this sum represents a considerable payment by the relatively small proportion of families who purchase nursing service annually.

The idea of spreading the cost of medical care and health services over a period of time and among a large group of people appeals to an insurance-conscious nation. The system of fixed monthly payments for which care will be received when needed seems the logical way to guard against large, unexpected medical bills as well as to promote good health.

A substantial proportion of our population now has some degree of protection against hospital and medical bills. Most of this protection is provided by three types of programs: Blue Cross hospital plans, Blue Shield medical plans sponsored by state and local medical societies, and insurance company hospital and surgical group contracts. In these three programs effort has been concentrated on providing care for catastrophic illness, with the result that hospitalization, surgery, and maternity care in varying amounts are the principal benefits provided. With the exception of general duty nursing in the hospital, which is included in the total per diem cost, almost no nursing care is available through such programs.

More comprehensive medical care, that is, physician's care in the office, home, and hospital, is provided by many of the smaller and older health insurance plans, such as those established for the workers of a particular industry and plans operated by consumer groups or by groups of physicians in private practice. A number of these plans provide special duty nursing when required in the hospital and home or hourly visiting nurse service, and a few include both services.

The nursing profession has had a long-standing interest in health insurance. As far back as 1916 a Committee on Health Insurance composed of representatives from the

Miss Klem is a member of the Division of Industrial Hygiene, Public Health Service, Federal Security Agency, Washington, D. C. *The opinions expressed are those of the writer and do not necessarily represent the views of the Federal Security Agency.*

then three national nursing organizations was studying the subject. In 1936 the American Nurses' Association and the National Organization for Public Health Nursing formed a joint committee to study health insurance and its implications for nurses. Interest has continued since that time, and the platform for the American Nurses' Association for 1950-52, as adopted by the House of Delegates, included a recommendation that nursing in prepaid health and medical care plans be promoted. At the Biennial Convention the NOPHN members passed a resolution that the NOPHN join with the ANA in requesting the cooperation of the AMA and other professional and health organizations in bringing about the inclusion of nursing service in medical care plans. This is in line with the belief that coordination of medical and allied services is the most effective method of providing health services and, consequently, that it is not advisable to set up a separate prepayment plan for nursing. A recent publication of the Committee of the ANA-NOPHN on Nursing in Medical Care Plans stated:

> As nursing care is considered an essential component of a comprehensive medical care program, and its provision a responsibility of the nursing profession, nurses have become increasingly more interested in how to include their services in more of these plans. Nursing service is not needed for all conditions, but, when it is needed, provision for it is important.[1]

Opportunities for Nurses in Present Programs

The fact that current health insurance benefits are principally for hospitalized illness suggests that hospital plans are the most likely programs through which prepaid nursing could now be provided. Because Blue Cross plans are designed to fit local needs and resources, are locally administered, and can have direct day-by-day working relationships with the hospitals and nursing organizations, they are the logical programs for experimentation. Hospital plans have already extended their benefits to provide new drugs and treatments on a prepayment basis. The inclusion of special nursing, in the hospital and home, and of visiting nurse service would be another step in the same direction and could prove valuable to both patient and plan.

Special duty nursing

Many prepayment programs fear the demand for special nurse service which might result from including it among their benefits. Programs now providing the service make it available only when the patient's condition, as determined by the attending physician, indicates a need for it. Apparently this method has proved successful in the older types of programs since a survey of 229 prepayment medical care plans made in 1945 showed that 33 percent of the 5,000,000 persons eligible for medical care through these plans were eligible for special nurse service.[2] Prepayment programs sponsored by medical societies in the states of Washington and Oregon—the oldest medical society programs in operation in the United States—made this type of care available to 80 percent of their members. Doctors operating private group clinics on a prepayment basis guaranteed similar care to 40 percent of their membership. A large proportion of the membership in industrial plans sponsored by employee groups or jointly by employers and employees were also eligible for special duty nursing.

The cost of special duty nursing in the hospital, if restricted to critically ill patients, would represent only a small percentage of the total hospital bill for all beneficiaries. Although additional experimentation is needed to provide a basis for determining the cost of such service, the experience of the prepayment programs now providing it and of such programs as the wartime emergency maternity and infant care program operated by the Children's Bureau are already available. Records of the EMIC program, for example, show there was no extensive use of special duty nursing for maternity and infant cases. Requests for service were made in fewer cases than had been anticipated, and in every instance special duty nursing was urgently needed. The cost of special duty nursing accounted for less than one percent of the total bill for hospital care and special duty nursing combined.

Visiting nurse service

Providing home nursing care for both long-term and shortterm illnesses as an adjunct to prepayment hospital benefits would be advantageous from many angles. If proper nursing services were available in the home and the home situation satisfactory, the attending physician might prefer not to hospitalize certain patients and to shorten the hospital stay of others. Both patient and prepayment program would benefit by this procedure. The hospitals also would have a particular interest in it, since reducing hospital stays for old cases would provide an opportunity for the admission of new patients and a fuller use of the hospital's auxiliary services. An additional incentive to hospital cooperation would be the hope that a decrease in the average length of stay would reduce the need for expansion and additional capital investment.

If such a program is developed the use of existing visiting nurse associations or the nursing service of the local health department seems the most logical method of providing the service. The visiting nurse agencies have had extensive experience in providing home care to individuals and groups, and their long years of administrative experience should be valuable in promoting medical care programs and in increasing their effectiveness. The use of visiting nurse service in connection with Blue Cross plans might be expected to result in more extensive use of nursing services in illnesses not paid for on a prepayment basis.

Opportunities for Nurses in Possible Future Programs

The advance in the medical sciences in recent decades has resulted in the development of many specialties and has tended to emphasize the treatment of an illness or a condition rather than consideration of the whole patient. The hospital and the physician's office rather than the home have become the places of treatment, and this development further obscures the individuality of the patient. This undesirable trend has been the subject of much discussion during the last few years. Concrete attempts are now being made to put the patient "back together again" by treating him as an individual and recognizing the importance of his home and other social and economic factors in his environment. Nursing will have an important part in any prepayment program that accepts this new concept of the patient as a total person and makes provision for coordinating preventive, diagnostic, curative, and rehabilitation services. This wide range of activities will result in increased opportunities for both the professional and practical nurse, will make for the most effective use of nursing skills, and lead to an expansion of nursing specialties.

Many groups of potential patients would profit greatly by the provision of nursing services under prepayment arrangements. The chronically ill and the aged, the recipients of public assistance, and workers in industry have been selected for discussion.

Care for the chronically ill and the aged

Administrators of prepayment programs are well aware of the increasing medical needs of the chronically ill and the aged. The percentage of the population over sixty-five years of age has almost doubled within the last fifty years, and within the next ten years this group is expected to represent almost one tenth of the country's population. Chronic conditions which now afflict one sixth of the population are not limited to the aged, however, since one half of the chronically ill are under forty-five years of age. A comprehensive medical care program, with benefits available in the office, home, and hospital, is essential to the proper care of these groups, and nursing—particularly home nursing—is of great importance among the services which should be made available.

The advantages of caring for the aged and chronically ill by an extension of hospital care into the home through home visits by the physician, the extensive use of home nursing, social service, physiotherapy, and vocational rehabilitation, have been amply demonstrated in New York City at Montefiore Hospital and at the municipal hospitals. With an experience of almost three years in the field of comprehensive home care under hospital auspices, Montefiore Hospital found the

cost of such care on a comparative basis, much less than the cost of ward care.[3]

In the opinion of Dr. Leonard Scheele, surgeon general, U. S. Public Health Service, the home care project developed at Montefiore Hospital is destined to be emulated in many parts of the country. According to him, the outstanding characteristics of the program are the planning and teamwork which assure the patient continuous supervision and expert care, without the often fatal break between hospital service and discharge to the home or to a nursing or boarding institution.[4]

If medical care insurance plans work out arrangements to participate in such programs, the visiting nurse associations, the nursing divisions of health departments, and other organized nursing groups might play an important part in them as they have in the demonstration programs. The American Medical Association recently directed its Council on Medical Service to study the feasibility of including nursing services in voluntary health insurance plans. Representatives of the council met with representatives of the ANA-NOPHN Committee on Nursing in Medical Care Plans and representatives of Blue Shield and commercial insurance companies in New York in November 1950 to discuss problems involved in providing nursing service in prepayment plans.

Care for public assistance recipients

The 1950 amendments to the Social Security Act (Public Law 734) may have important implications for the future development of prepayment medical care organizations of all types. Prior to its enactment, the Federal Government did not participate in meeting the cost of medical care provided public assistance recipients when the payments for such care were made directly to physicians, nurses, dentists, hospitals, prepayment plans, and other vendors of medical service. One of the basic public assistance provisions of the Social Security Act is that grants be made in cash to the recipient if federal matching is desired. The amendments, although not providing additional funds for medical services, recognize that medical needs are unpredictable and that it may be more feasible to meet the costs through direct purchase of medical care in behalf of assistance recipients than through the money grant.

It has been estimated that prior to the amendments about $125,000,000 was being spent each year for medical care provided to public assistance recipients. About two thirds of this sum consisted of payments made directly to persons or organizations providing care and consequently was not eligible for federal matching. The establishment of a fund made up of monthly contributions for each person on the assistance rolls, regardless of his need for medical care that month, has been recommended by the American Public Welfare Association, the Social Security Administration, and others directly concerned with the provision of medical services to relief recipients, as the desirable method of meeting medical costs. The Committee on Medical Care of the American Public Welfare Association is doing everything in its power to persuade the states to take advantage of the authority granted them under the amendments to experiment in providing medical services to relief recipients under various arrangements.

Since federal money is now available for matching, public agencies will be increasingly involved in developing working relations with the medical profession, hospitals, public health officials, and other groups to improve the quality and quantity of medical care for the 5,000,000 persons receiving assistance under the Social Security Act. New plans are now being developed in some states to take advantage of the authority granted under the amendments which became effective on October 1, 1950. An article dealing with the amendments and their importance to nurses will appear in an early issue of this magazine.

State disability insurance programs and nursing services in industry

Much of the recent growth in prepayment plans has been due to coverage of industrial workers as a result of the widespread inclusion of health and welfare clauses in collective bargaining agreements. The demands of unions also have been largely instrumental in obtaining an expansion of benefits in pre-

payment hospitalization plans, such as the raising of income limits for full participation in benefits, the extension in number of days of coverage, and the inclusion of many services hitherto excluded. As the value of nursing service in prepayment plans becomes more widely appreciated, it may be assumed that it also will be made a part of the service requested under collective bargaining agreements.

The passage of state disability insurance laws and the need for in-plant medical service makes the expansion of industrial nursing service one of the most immediate and important areas for guaranteeing an additional source of income to the nursing organizations. Under state disability insurance programs the worker, when absent because of illness, receives the same cash benefit that is provided under state unemployment insurance laws when he is unemployed because of the lack of a job. These laws are now in operation in four states. It seems likely that this type of insurance will be extended in the near future since in twenty states during the last legislative session similar bills were pending or committees were working on the problem.[5] Because the tendency in state legislation is for the employer to pay part of the cost of the program, he has a financial interest in keeping his workers well and on the job. As a result he will have an increased interest in providing an in-plant medical program and in stimulating the development of a prepayment medical program which provides care for accidents and injuries not associated with industry, with emphasis on preventive services, family health counseling, and education.

It may be assumed that the larger industries, stimulated by the disability insurance programs, eventually will provide in-plant medical services by fulltime staffs. The smaller establishments without a sufficient number of employees to justify the fulltime services of a physician and nurse present the organized nursing groups with an unusual opportunity for service. Most nonagricultural workers in this country are employed in small establishments, about 40 percent being in plants with less than fifty employees and 71 percent in plants with less than 500. Attempts have been made in various areas to provide a service to groups of small plants but it is difficult to maintain a satisfactory program without continuous promotional attention. The provision of parttime nursing service under the direction of a parttime physician and with the continuing supervision of an organized nursing agency seems one of the best solutions. This is a different type of prepayment plan but its potentialities, as well as its difficulties, are indicated by the fact that over 95 percent of the industries in this country paying wages taxable under OASI employ fewer than fifty persons.[6]

Nursing service constitutes the care available in most small plants which now have any type of program, and in several instances visiting nurse societies are providing the care. In 1945, 25 agencies which were serving industries on a parttime basis submitted comprehensive data in response to a NOPHN questionnaire.[7] These agencies served 75 plants employing approximately 24,000 workers. Sixty of the plants employed under 500 workers; 9 employed between 20 and 75 workers. A total of 1,020 hours of nursing service per week was provided.

Six nurses on the staff of the Detroit Visiting Nurse Association are now giving service to 8 small plants, 1 on a fulltime and 5 on a parttime basis.

The Philadelphia Visiting Nurse Society has 6 nurses assigned on a parttime basis to 6 small plants whose working force ranges from 150 to 400 employees. The Visiting Nurse Service of New York provides service to 6 small plants employing 200 to 300 workers. Of the 5 nurses assigned to this service, 3 give fulltime and 2 parttime service in these plants.

Table I shows the nurses' and physicians' hours of service in these plants in relation to the size of the plants.

The opportunity of the nurse in the small plant to promote the health of the worker is shown by the detailed information about services provided in 1949 in Detroit and New York. In the plants served by the Detroit VNA, 12,138 visits to the dispensary were made at which 14,152 services were given. Of these services, 7,304 were classified as

TABLE I. Number of hours of physician and nurse time provided in small plants, in three cities

New York City			Philadelphia			Detroit		
Number of Employees	Number of Hours per Week (serving two shifts of workers)		Number of Employees	Number of Hours per Week (serving one shift of workers)		Number of Employees	Number of Hours per Week (serving one shift of workers)	
	Nurse	Physician		Nurse	Physician		Nurse	Physician
200	12	4	150	4	1	35	2	on call
200	15	6	150-175	12½	½	120	40	" "
200	15	5	300	5	2	135	10	" "
250	25	5	350	9	4	150	6	" "
300	27	5	350	10	2	175	4	" "
300	27	5	400	6	5	200	4	" "
						258	7½	" "
						450	10	" "

occupational, 5,502 as nonoccupational, and 1,346 for counseling only. In the six small plants given service by the VNSNY, 18,131 visits were made to the dispensary. Of these, 7,790 were for nonindustrial accidents and illnesses and 5,365 were of industrial origin. The worker's desire for health guidance is indicated by the 2,851 visits to the nurse or doctor that were designated as "health promotion visits." During the year, 1,191 preemployment and annual physical examinations were given and, prior to the examination, 934 visits were made to allow the nurse time to take a medical history. The value of these services would be greatly enhanced if the workers belonged to a prepayment program with which the work of the in-plant nurse could be coordinated.

Experimentation

While the contribution which the nurses can make to prepayment programs is extensive, there are many unsolved problems inherent in the organization and administration of nursing services on a prepayment basis. As the nursing associations themselves have indicated in a recent publication of the joint ANA-NOPHN Committee on Nursing in Medical Care Plans, the solution of these problems will come only from experimentation and shared experience.[1] The available information on providing nursing services under prepayment arrangements is limited as only a few of the plans now include it among their benefits; in some instances, however, it covers a considerable number of years.

Nursing benefits under HIP

One large program, the Health Insurance Plan of Greater New York, which includes nursing care among its extensive medical benefits, although more recently established, has been in operation long enough to provide valuable information on services provided, costs, and the effect of different financial arrangements on the volume of nursing care requested.

HIP, the central agency, collects premiums and distributes the money to each medical group affiliated with it, in accordance with the number of persons who have selected that group. HIP retains enough funds to cover administrative and operational costs which during a certain period included the partial cost of nursing service. During other periods the medical groups paid a part of or the total cost of nursing care from their own funds. During the first stage, March 1, 1947, through June 30, 1948, HIP paid 80 percent of the total cost and the medical groups paid 20 percent. The nursing organizations during this period were paid on an actual cost per visit basis. During the second stage, July 1, 1948, through June 30, 1949, the medical groups assumed the full payment and the nursing organizations continued to be paid

on an actual cost per visit basis. During the third stage, July 1, 1949, through June 30, 1950, the medical groups established a Special Service Fund from which the nursing organizations were paid. During this third stage, however, the nursing organizations were paid on a different basis, namely, a capitation basis, and therefore the amount of the service provided by the organization had no effect on the total income received by them. This type of financial arrangement is still in existence.

The utilization of service and the annual cost during the various time periods are given in Table II.

In order to insure adequate funds to provide for an unusual amount of service, the estimate used in the original planning was deliberately increased about 50 percent and was set at 300 nursing visits per year for each 1,000 insured persons. During the first year of operation, nursing visits were only about one tenth the original high estimate. When compared with physician's visits, the ratio was 1 nurse visit to 127 physician's visits of all types, and 1 nurse visit to 16.6 physician's home visits.

The visiting nurse agencies providing services to HIP members are permitted to accept a request for an initial home visit directly from the patient, but services cannot be continued without medical supervision.

Although the use of the capitation method of payment (a specified amount per person eligible for service) seems to result in more cases receiving nursing visits, other factors also were involved. These include a growing awareness of the value of nursing service on the part of the physicians, not only in connection with illness but also as a means for health education and guidance for the entire family. It is anticipated that the requests for nursing service will continue to increase since the plan has always emphasized its preventive program, an area in which the services of the visiting nurse are particularly valuable. Neither HIP, the medical groups, nor the nursing organizations believe that the final and most satisfactory arrangement for providing nursing service has been developed. Their willingness to experiment has been described by Marian Randall, executive director, Visiting Nurse Service of New York, as one of the most important features of HIP's nursing program.[8]

Experience at HIP as well as at Montefiore and Bellevue hospitals has indicated that it is advantageous to have a highly qualified public health nurse work directly with the medical groups in planning for and coordinating visiting nurse service. The duties of the nurse coordinator in the home transfer program at Bellevue Hospital were recently outlined in a description of that program in this magazine.[9]

Blue Cross experiment in Philadelphia

Another interesting experiment is under consideration in Philadelphia where at the present time the Nursing Council, the Hospital Council, the Visiting Nurse Society, and the local Blue Cross are working on plans for a demonstration project under which visiting nurse service will be provided to certain Blue Cross members after hospitalization. Not all discharged hospital cases will be eligible for home visits; necessity for care will be determined by the responsible medical authority. Eligibility for care will also depend upon the type of illness or condition; it is proposed that care be restricted to a specified list of diagnoses developed by the local medical group and the visiting nurse organization. The results of the demonstration will be of great value to all other Blue Cross plans, the hospitals, and the visiting nurse organizations which have long been interested in exploring this avenue of service. An additional incentive is the fact that the visiting nurse organizations are faced with the necessity of finding funds to replace the support now given by the Metropolitan Life Insurance Company. The discontinuance of that service by January 1, 1953, is discussed in another article in this issue of PUBLIC HEALTH NURSING.

Additional information which will be of help in planning for the inclusion of nursing service in prepayment plans may be found in the nursing programs designed to provide care for special population groups, regardless of whether or not such plans are financed on a prepayment basis. The experience gained

TABLE II. UTILIZATION OF NURSING SERVICE, HIP

Financial Arrangements	Utilization of Nursing Service per 1,000 Members		Cost per 1,000 Members*
	Number of Cases Visited	Number of Nursing Visits	
First stage:			
March 1-December 31, 1947	9	26	$ 64
January 1, 1948-June 30, 1948	8	50	122
Second stage:			
July 1, 1948-December 31, 1948	4	24	59
January 1, 1949-June 30, 1949	3	12	29
Third stage:			
July 1, 1949-December 31, 1949	4	17	41
January 1, 1950-June 30, 1950	11	42	100

* Based on average cost of $2.45 a visit.

by the Department of Agriculture in its extensive use of nurses in the Farm Security Administration and War Food Administration health programs is an important source of data. To make more judicious use of physicians' services in caring for seasonal workers and to provide a continuous program of preventive services, clinics and health centers in charge of registered nurses were set up in 250 or more areas. The nurse, as the fulltime employee, was the keystone of the preventive as well as the therapeutic medical program in these clinics.[10]

The EMIC programs demonstrated, among many other things, the value of nursing participation in the initial planning and policy making activities in any program including nursing. The EMIC program also indicated the need for making housekeeping and practical nurse care available as part of a comprehensive medical program to insure that the services of the professional nurse will be used to best advantage.[11]

Summary

Although the present supply of nurses is limited and will become more so as the needs of the armed forces are met, the inclusion of both special duty and visiting nurse services in benefits provided by prepayment plans is both possible and desirable. In addition to providing a satisfactory method of budgeting the cost of nursing service, the prepayment programs offer one of the best possibilities for using the practical nurse under supervision and for assuring that the work of the graduate nurse is restricted to the use of her special skills and that her services are received by the persons most in need of them.

The inclusion of nursing services in prepayment programs will depend on the willingness of the hospital, the physician, and the nurse to participate in demonstration programs which will provide a body of information on the values and costs of such service. The leaders of the nursing profession and of local nursing groups can influence the rapidity with which nursing benefits become available by their interest and initiative in informing departments of welfare, industry, officials of prepayment plans, and the general public about the benefits to be derived from nursing services in prepayment plans. Local and state nursing groups might seek information on medical care insurance plans now established and those in development stages in their own localities, and offer their services in planning for the inclusion or broadening of nursing benefits in such plans.

The full development of nursing service depends upon recognition by the physicians and the public of the contribution of such programs to family and community health. Only when this awareness is developed can we anticipate any substantial growth of nursing service in prepayment plans.

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Common Ground for Common Objectives in Public Health

(Continued from page 7)

point the common objectives that emerge, then the purposes and methodology of the team approach take on added meaning. There is, however, a grade or degree of cooperative endeavor which is perhaps on an even higher level than teamwork in the ordinary sense. I refer to partnership.

There is the partnership between the volunteer and the professional worker, between voluntary and governmental agencies, among the citizens, the professional workers, and the government, and among the several professions. In no other country in the world are there quite the same opportunities as there are here for establishing working relations on a partnership basis among the citizens, the board members, the professional workers, and the local, state, and federal government. Partnership, I believe, is both a means and an end in itself. It entails a mutual and growing confidence in those with whom we are working; it suggests a common purpose arrived at and accepted through a spirit of dedication; and, most of all, it connotes an element of sacrifice, for any partnership requires that each member must give up something in order to attain a greater good. It seems to me, therefore, that partnership should be both the goal and the method of all agencies working in the field of public health. The programs of our own agencies are important, but only as they contribute to the whole; and the concept of the whole can never be gained except through the constant interplay, give-and-take, and exchange of knowledge and wisdom which are the fruits of partnership.

This article is based on an address given at the annual meeting of the New York City Public Health Association in June 1950.

Priorities for Public Health Nursing Visits

MARGARET S. VAUGHAN, R.N.

One answer to the ever-increasing demand upon the time of the public health nurse in the local health department

OUR PROBLEM WAS altogether a familiar one: How can administrators, medical and nursing, provide concrete and workable guidance for the public health nurse in the local health department who is faced with more demands for nursing service than she can meet. The oft-repeated explanations of shortage of personnel, inadequate supervision, and lack of citizen participation are only partial answers, and they fail to solve the difficulty. Admitting these handicaps as contributing factors in our situation, nevertheless, we in Arkansas determined to tackle the problem and to find a better way to help the local public health nurses plan their time so as to cover the most urgent needs first.

The problem was recognized as basically one of supply versus demand for nursing services. The situation had become so acute that many of the public health nurses admitted to their supervisors that they felt frustrated and discouraged. Increasing pressure from the directors of the various divisions for individual service and inability to meet these requests appeared to be the main reasons for these reactions. Nursing service to the family as a unit had of necessity decreased as the nurses had attempted to satisfy requests from the Central Office for follow-up in the specialized fields.

One of the nurses expressed her sense of frustration graphically in these words: "The State Department of Health is like an octopus with each of its long arms reaching out for my time and eventually crushing me because of the impossibility of accomplishing what each program director desires."

As a first approach to the growing dilemma, a joint conference of those concerned—the medical directors of the various divisions of the State Department of Health, the director of the Division of Public Health Nursing, and the consultant nursing staff—was planned. As each program director had a definite stake in the situation, his interest and attention were immediately evident. The group decided that they would have to give the matter consideration over a period of time to find an effective solution, and monthly conferences were initiated.

SETTING PRIORITIES

It was a "give and take" situation for all at the conferences, for obviously the one public health nurse, representing in most communities the total local staff, could not be expected to give the desirable coverage to all phases of the program. What portion of each separate program should be included in the "must" schedule of the public health nurse? It was agreed the core of the matter was wise case selection in each program area. This led to an effort to set up criteria for priorities in case selection based on the prevention-potentials usually accepted by public health workers. After careful thinking and joint

planning the group developed an outline of priorities in each area. (See page 19.)

WORKING OUT THE MECHANICS

The next step was to put the plan into action. Here we were on more familiar ground and we relied upon several time-honored public health nursing planning devices: (1) geographical division of the county into working areas (2) physical aids—yearly, monthly, and daily schedules, as well as work plan cards for the tickler file. The mechanics of these devices were worked out in a more refined degree than is usually customary in public health nursing.

Briefly, the county was divided into working areas according to (1) population density (2) highways and roads (3) other significant physical features. The size of each work district was roughly limited to an area which could be covered completely in a half day's travel time, thus leaving at least one half of the day for actual service in the community. These basic divisions were plotted arbitrarily, irrespective of the number of nurses currently employed in the local department and the existing caseload. A redistribution of the work areas thus established will be considered when the nursing staff is increased. This concept of assigning distinct already plotted work areas to all types of personnel of a local department impressed the directors of other bureaus, notably the Bureau of Sanitary Engineering, as an expedient method of carrying out their specific programs.

Plotting work areas along arbitrary lines offered another advantage, namely, the designation of each district by an accepted code number. Interest in this had developed in the Division of Tuberculosis Control which had adopted the IBM system of coding significant data about tuberculosis cases. Such a procedure seemed equally feasible should the directors of other special divisions eventually wish to accumulate information regarding their specific programs.

The work districts were marked on a large county map. An analysis of the current caseload was made to determine priority designation of each type of case. A small plastic tab of the color chosen to indicate a certain priority rating was put on a work card for each individual carried. The card was then placed in the nurse's tickler file.

SCHEDULING TIME

A schedule was next made assigning a definite day or portion of a day to each work area. More time was scheduled for areas in which the caseload analysis showed special problems but every area was to be visited by the nurse at least once a month. With agreement by the joint conference groups on these preliminary steps the way was open for introducing the new procedures to the local health departments.

While these remarks may leave the impression that the pivotal worker, the local public health nurse, was overlooked in the early steps, let me assure you that the opposite is true. Since administrative decisions and administrative planning were the most important factors in the first two steps of this procedure, no local public health nurse participated directly in these early stages. Her point of view was represented constantly, however, by the active participation of the entire supervisory and consultant nursing group. After the general plan was formulated, selected local public health nurses were invited to share in the discussions in the Central Office and to express their opinions freely about the plan. The tryout of the plan was first made in a nearby local health department where both local and state personnel worked together through all of the preliminary basic steps. After this, it was the consensus that the plan which had been developed, although unproven on the testing ground of the separate local health departments in the state, had passed its first test of workability. Two local public health nurses were ready to put their schedule, with all of the new implications woven into it, to a local trial.

PRESENTING THE PLAN

In view of the fact that few of the local health departments in Arkansas have fulltime medical directors, the most feasible way to present this newer procedure to this group appeared to be at a joint conference of the division directors and the state nursing staff.

This was arranged during the annual conference of the health department. Similarly, the general plan was presented and explained to all local public health nurses at a nursing section of the conference. Both of these groups indicated their interest in the procedure and assured us of their desire to receive help in setting up the system in the local departments. The entire plan was then prepared in writing by the nursing staff, mimeographed, and carried by the state consultant staff on their subsequent visits to the local health departments. The plan has been a part of all local staff education conferences held since and is also included as a phase of instruction during the orientation period of all new nurses.

The limitations of the recommended basis for case selection have been recognized and in interpreting this procedure to the local public health nurses due emphasis has been given to the following factors: It is recognized that the priority criteria, serving as a guide and not a fixed determination, help the nurse decide what types of situations must receive her first attention. Thereafter as the patient receives nursing supervision and help in solving his health problems, his priority status will frequently change to a lower, or perhaps, eventually to a zero position. To use the procedure effectively, the nurse must constantly evaluate the status of the families under her supervision and on this basis plan to increase or decrease the amount of supervision she will give.

Although it is too early to evaluate the effectiveness of this procedure in terms of improvement in actual service rendered by the local public health nurses, we believe that results thus far have been encouraging. Interest has been created among the local public health nurses; encouragement has been given, replacing somewhat the frustration and inadequate planning observed; and requests from the local public health nurses for help in planning their programs can be answered more specifically now than previously.

One of the local public health nurses recently gave this evaluation of the new procedure: "It has done more to help me keep up with my caseload than anything we have ever had; it saves my travel time, and helps me keep in closer contact with my communities."

Priorities in Case Selection

Grade I

RED (identifying color)

(This always indicates immediate action but the nature of the problem determines whether the visit must be made at once or within 24 hours. Few situations need to be considered "emergencies" for public health nurses but the 3 listed here are considered in this category. The nurse is instructed to cancel any type of work previously scheduled and give attention to any of these 3 situations.)

At once

Maternal and child health

1. Premature infant
2. Maternity case with symptoms of toxemia, eclampsia, or bleeding
3. Acute burn

Within twenty-four hours

Communicable disease

1. Poliomyelitis
2. Epidemic meningitis
3. Diphtheria
4. Smallpox
5. Suspected rabies
6. Typhoid fever
7. Scarlet fever
8. Septic sore throat

Maternal and child health

1. Ophthalmia neonatorum
2. Cleft lip and/or palate in the newborn
3. Acute osteo (new)

Tuberculosis

1. Massive tuberculosis meningitis
2. Acute hemorrhage
3. Generalized miliary tuberculosis in infants

Venereal disease

1. Infant born of syphilic mother, inadequately treated

2. Contact to known infectious primary or secondary case

Grade II

ORANGE (identifying color)

(Although a definite time limit for this category has not been specified, every orange-colored tab indicates an urgent need for a home visit.)

Communicable disease

1. Tularemia
2. Rickettsial diseases
3. Malaria

Maternal and child health

1. Complicated maternity cases referred by University Hospital, midwives, or private physicians
2. Cases sent home from hospital with casts, new braces or appliances, or any other condition in which close follow-up is indicated
3. Cases of diarrhea under two years not under physician's care
4. Any case where formula demonstration is requested by physician
5. All maternity cases having
   a. Tuberculosis
   b. Heart trouble
   c. Untreated syphilis

Tuberculosis

1. Patients who have left tuberculosis sanatoria against medical advice
2. Positive sputum cases in the home
3. Diagnosed cases in the home with unknown sputum status
4. Provisional diagnosis of "tuberculosis suspect"
5. Child under six with "active primary"
6. Suspects discovered from mass x-ray survey not cleared within three weeks from notification
7. Newly diagnosed skeletal tuberculosis

Grade III

YELLOW (identifying color)

Communicable disease

1. Chronic typhoid carriers

Maternal and child health

1. All postpartal maternity cases having had a stillbirth at this pregnancy
2. All congenital deformities in the newborn
3. Severe nutritional disorders in infants and young children
4. Any acute problem in a school child except infestation
5. Routine ante- and postpartal cases, mother and infant

Tuberculosis

1. Active tuberculosis with negative sputum
2. Quiescent, including pneumo-arrest

Grade IV

GREEN (identifying color)

Communicable disease

1. Immunization clinics

Maternal and child health

1. Routine teacher-nurse conference and home follow-up
2. Midwife home visits
3. Infants and preschool children with special problems, or those in any problem families

Tuberculosis

1. Apparently arrested
2. Arrested tuberculosis
3. Contacts
4. School child with old "primary active"

Grade V

BROWN (identifying color)

Maternal and child health

1. All infants, preschool children, not otherwise classified

Miss Vaughan is director of the Division of Public Health Nursing, Arkansas State Board of Health. She writes she will be glad to answer requests for more detailed information or other specific questions. In Arkansas the supervisors from Central Office have assisted all the local public health nurses in setting up their records for home visits according to the plan. There has been uniformity in interpretation which has gone far to assure smooth functioning of the plan although some snags still exist.

A Joint Attack upon Chronic Disease

I. JAY BRIGHTMAN, M.D.
HERMAN E. HILLEBOE, M.D.

CHRONIC DISEASE has become the chief public health problem of the day, and its magnitude at first sight may seem overwhelming. However, achievements in the control of communicable diseases and the promotion of maternal and child health point the way to equal successes in a concerted attack on chronic illness.

To achieve realistic objectives in the field of communicable disease numerous public health technics were developed, some of which had to be discarded when found wanting while others stood the test of time. The effective application of such technics required the cooperation of various community groups, such as the medical profession, hospitals, official and voluntary social agencies, and schools, all of which worked closely with our fulltime teams of health officers, public health nurses, and sanitary engineers.

In recent years these services have been augmented by procuring from official and voluntary sources such specialized personnel as nutritionists, medical social workers, and consulting nurses in the fields of infant care, hospital technics, and mental health. The lowered mortality and morbidity rates of acute communicable diseases and the drastic reductions in the maternal and infant death rates illustrate the great accomplishments of these programs.

Since the causes of morbidity and mortality are changing, it is necessary to redefine major objectives and to reassign priorities. It must be emphasized that no loss of ground should be allowed in fields where success has been realized. While maintaining hard-won advances, a vigorous attack on chronic disease must be pressed forward. Mortality records make such action imperative. In 1900 in New York State three of the first five causes of death belonged to the communicable disease group, namely, tuberculosis, pneumonia, and enteritis in children under two years of age. In 1949 not any of the five leading causes of death was in that category; rather, four belonged to the group of chronic degenerative diseases. These were: heart disease in first place, cancer and intracranial vascular accidents, second and third, and diabetes, fifth. Fourth place fell to accidents, which have an indirect relationship to the chronic disease problem. The majority of accidental deaths occur among older people and are frequently associated with physical disabilities attributable to chronic illness.

The challenge presented by chronic disease is only too evident. In developing a new public health program it is necessary to evaluate current public health technics to determine which can be effectively utilized and what new methods must be established.

Most health departments already have well organized programs directed at the control of some of the chronic diseases. These include special programs for cancer, tuberculosis, venereal disease, poliomyelitis in children and adults, and physically handicapping conditions, such as rheumatic fever, in per-

Dr. Hilleboe is commissioner, New York State Department of Health, and Dr. Brightman is assistant commissioner, Division of Medical Services, in the department.

sons twenty-one years of age and younger. More recently we have seen the development of demonstration programs directed at control of adult heart disease and diabetes.

Individualized approaches are necessary when specific preventive measures are available for the particular disease. Also, from the viewpoint of legislative appropriations and fund raising by voluntary organizations, emphasis upon specific diseases may be more effective in producing the necessary funds than would an appeal for money for the general chronic disease problem. However, many control measures, such as health education, early casefinding, medical and institutional services, professional training, and rehabilitation, can be broadly applied to serve several different diseases simultaneously. In such instances a combined approach will result in a more efficient and effective program at a significantly reduced cost.

A public health chronic disease program must have three major objectives: (a) the prevention of disease (b) the early diagnosis and treatment of disease and (c) the rehabilitation of the patient whose functional reserve has been reduced as a result of disease or injury.

Prevention

In the field of prevention it is essential to consider each of the chronic diseases separately because prevention implies removal of the specific cause. Unfortunately, our information regarding the etiology of the major chronic diseases is inadequate and therefore we do not have specific measures which can be applied with reasonable assurance that the disease will not occur.

However, there are certain helpful indications which should be fully exploited, so that all possible gains can be made. In doing so it is likely that new approaches will suggest themselves and these may be brought into the program as speedily as they prove practicable.

Heart disease

The problem of heart disease must not only be considered apart from that of other chronic illnesses but must be separated into its various categories before one can talk about preventive measures. We have little information about prevention of the two major forms of heart disease, namely, the arteriosclerotic and hypertensive types. Yet, we do have some evidence that arteriosclerosis may be associated with the inability of certain persons to metabolize cholesterol adequately. Some physicians are placing persons with early evidences of arteriosclerosis, as well as persons with family histories of this condition, on low cholesterol diets. Essential hypertension, the precursor of hypertensive heart disease, is often favorably influenced by a diet low in sodium. The nutrition and nursing services of the public health program can be of great aid to both physician and patient in the application of these dietary measures.

The great progress of the past can continue in the control of rheumatic heart disease. Recurrences of rheumatic fever may be significantly reduced by the use of antibiotics, particularly during the winter months when sore throats and upper respiratory infections are most common. A sound program calls for adequate clinical facilities for follow-up of patients with rheumatic diatheses to detect the earliest signs of recurrence and hospital and convalescent home facilities of high quality for the care of rheumatic patients during the periods of acute illness.

Some cases of congenital heart disease are associated with the occurrence of German measles in the mother during the first trimester of pregnancy. Thus, control of this disease is important in order to reduce the danger of exposure of pregnant women. Subacute bacterial endocarditis may be reduced in incidence by the administration of antibiotics to all patients with rheumatic or congenital heart disease prior to and immediately following oral or pharyngeal surgery. An educational program for both physicians and patients will help to accomplish this reduction.

Cancer

In the field of cancer we do have information regarding the relationship of certain industrial chemical agents to the development of malignant tumors. Steps have been taken

for the elimination of these industrial hazards. Recent information has indicated that cancer of the lung may be related to the inhalation of cigarette smoke. If these studies are confirmed, a change in our smoking habits through an intensive educational procedure would certainly be of benefit in the prevention of pulmonary cancer.

Unfortunately, there is at present no practical approach to the prevention of other leading causes of illness and death, such as diabetes, arthritis, nephritis, or intracranial vascular accidents.

Obesity

The promotion of good nutrition is one general health measure which can be applied to chronic disease control. As is well known, obesity among persons more than forty years of age is far too prevalent. While not a specific cause of any chronic disease, obesity is known to be an aggravating factor in such conditions as diabetes, hypertension, arthritis, and heart disease. Indeed, some of the milder forms of these conditions can be brought under control by weight reduction. As a corollary, the symptoms and serious effects of these diseases may sometimes be delayed or even avoided by adequate weight control. The promotion of obesity control through public health education and through direct assistance to patients and physicians by public health nurses and nutritionists is an essential part of the chronic disease program.

Early Treatment

Through early detection and treatment of chronic illness the progress of the disease may be arrested and complications avoided. The necessary measures may be classified in three categories: early casefinding, assistance to practicing physicians, and assistance to patients.

1. *Early casefinding.*—Early casefinding depends upon public health education activities which encourage frequent examinations and upon the development of adequate facilities for such examinations. Several procedures are already available and others may be developed. The following activities enter into the early casefinding aspects of the chronic disease program:

a. Periodic health examinations by the family physician. This item is mentioned first because it has the greatest potentiality for reaching the largest number of patients.

b. Follow-up of infants whose birth certificates record any evidences of congenital heart malformations and also of infants born of mothers who contracted German measles or other infectious diseases during the first trimester of pregnancy.

c. Child health conferences for infants and preschool children.

d. School health examinations.

e. Industrial preemployment and follow-up examinations.

f. Insurance examinations.

g. Detection clinics.

h. Multiple disease screening clinics.

It must be emphasized that while positive findings are of great value in suggesting the need for care and treatment, negative findings are no guarantee of the absence of asymptomatic chronic disease. Unfortunately, our diagnostic aids are not yet sufficiently sensitive to detect all latent abnormalities which may progress to chronic illness some time after the examination.

Multiple disease screening clinics constitute a relatively new approach to mass casefinding of chronic diseases. In the past heavy emphasis has been placed upon mass examinations for individual diseases, such as tuberculosis, nephritis, diabetes, and cancer. While single approaches are effective these methods are more costly and not so productive as when they are used in combination. In multiple disease screening use is made of a battery of laboratory or x-ray tests, each of which has proved to be fairly reliable in detecting evidence of a chronic disease in the asymptomatic state. Such tests are available for syphilis, diabetes, glaucoma, anemia, tuberculosis, and other chronic chest diseases, visual and auditory disturbances, hypertension, nephritis, heart disease, and several types of cancer (esophageal, gastric, and pulmonary).

The costs are relatively low as the screen-

ing tests can be carried out by technicians and nurses and the results determined by experts at their convenience. The examinations are more productive because of the many diseases covered. Positive results are only suggestive and not diagnostic; persons must be referred to their physicians for final diagnosis.

2. *Assistance to practicing physicians.*—A chronic disease program in a public health department can offer assistance to private physicians in the early diagnosis of chronic illness among their patients and in the provision of adequate care. These services include:

a. Medical consultations where questions arise regarding diagnosis or appropriate treatment.

b. Laboratory and x-ray facilities where specialized procedures are required for differential diagnosis or treatment.

c. Nutrition services for the precise management of patients on general, reducing, low cholesterol, or low sodium diets.

d. Public health nursing. As with the acute diseases, it is one thing for the doctor to prescribe therapy and quite another for him to be assured that his instructions are understood by the patient and will be carried out, especially in the home. Home nursing provided by official or voluntary agencies is of great value in rendering bedside service, interpreting doctor's orders to the patient and his family, and teaching good health habits in the home.

e. Professional education keeps physicians, nurses, and other health personnel informed on new developments in the medical approach to chronic illness. This can be achieved through the development of lecture programs, regional full-day or half-day institutes, and shortterm refresher courses.

3. *Assistance to patients and their families.* All services providing assistance to doctors are in reality services to the patients. Likewise, any service offered by the community program directly to the patient helps the doctor meet his own responsibilities in prescribing therapy. All community services to the patient should have the approval of the attending physician. These might include the following:

a. Facilities for convalescent care. Many patients with chronic disease require institutional care for prolonged periods either in general hospitals or in convalescent or nursing homes. A complete chronic disease program must provide for the establishment of an adequate number of beds in convalescent homes, for the maintenance of these beds in accordance with satisfactory standards, and for meeting the cost of such convalescent care.

b. Home care. In many instances, the home can be used for prolonged bed care for patients with chronic disease. This reduces the cost of care to the patient's family and to the community and frees additional beds for other purposes in the community hospital or convalescent home. This may entail extension of treatment services to the home so that the home becomes essentially an annex of the hospital. Home care services include medical and nursing care, physiotherapy, occupational therapy, medical social work, nutrition, and housekeeping.

c. Housing. A home which may have been quite suitable for a family when all members were in good health may become very unsatisfactory when one member has developed a chronic disease. The structure of the home may make it necessary for the patient to climb stairs to reach his apartment or, in the case of the one-family house, to reach a bathroom or bedroom. The community program might well try to provide assistance for families who require a change in type of housing to meet the medical needs of a patient.

d. Medical social service. The occurrence of chronic disease in the family frequently causes considerable social and emotional upheaval. The services of the medical social worker can be of great value in interpreting to the family the nature of the problem and in attempting to bring about a satisfactory adjustment to the changed circumstances. A favorable attitude on the part of the patient and family toward the disease will go far in maintaining a high level of mental health, vitally important if the subsequent program of rehabilitation is to be successful.

Rehabilitation

Rehabilitation of the patient with chronic disease is an essential part of the total treatment program. As the prevalence of chronic disease continues to increase with the progressive aging of the population, failure to provide the means whereby patients can make the greatest use of their remaining func-

tional abilities will throw a heavy burden on the other elements of the population.

For some years many facilities have been developed for the rehabilitation of patients with physically handicapping conditions, usually orthopedic or neuromuscular in nature. More recently interest has been shown in the rehabilitation of the patient with other forms of chronic disease, namely, heart disease, arthritis, and diabetes. It is necessary to establish facilities to determine the working capacity of these patients and to reassure the patients that it is quite safe for them to work under modified conditions. They need training in adjusting their routine activities so that they may stay within their functional reserves, and employers must be urged to accept these patients as employees and to provide adequate working facilities for them. It is well known that many large corporations have found rehabilitated patients to be unusually reliable and desirable employees. (*Editor's note*: See "Employment of the Handicapped in Industry" by Florence M. Kumm, PUBLIC HEALTH NURSING, November 1950, page 613.)

Discussion

This article has summarized the various approaches that can be made in a program directed at the control of chronic disease through prevention, early diagnosis, adequate treatment, and rehabilitation. In the development of this program we have indicated the various categories of personnel and agencies whose cooperation must be achieved if the program is to be successful. These include the health officers, the public health nurses, the medical social workers, the nutritionists, the hospital administrators, the practicing physicians, the laboratory directors, the employers, the schools, and the many official and voluntary social agencies in the community.

The stake of the community in the chronic disease problem is large, economically and socially. Chronic diseases occur at all ages but the prevalence is greatest in the older age groups. If an unduly large number of persons reaching the later years of life are infirm, financially dependent, unable to take care of their individual needs, and generally frustrated, this will mean an unhappy situation not only for the elderly and ill but also for the younger and healthier members of the population.

The income-earning group between twenty and fifty years, the period during which people are endeavoring to establish and maintain their own families, will be burdened with the financial support of the older age groups. In addition, they will need to provide personal care for them in illness and to withstand the irritability and emotional instability associated with dependency and poor health. In turn, these burdens will have an effect upon the children because of the limitations thrown upon the family income with resulting lowering of the living standards, overcrowding, and lessened chances for higher education. The emotional strain thrown upon the parents will be reflected in the management of the children and the general morale in the home. This situation must not exist if we are to maintain our earlier advances in the field of child health.

These problems have received full recognition from various official and voluntary agencies. The United States Public Health Service has established a Division of Chronic Diseases to investigate specific chronic disease problems and to assist in state and community programs. In May 1949 there was established a Commission on Chronic Illness sponsored by four great national agencies interested in and directly affected by this problem: the American Medical Association, the American Public Health Association, the American Hospital Association, and the American Public Welfare Association. The commission is charged with making further analyses of the chronic disease problem, reviewing and evaluating the approaches being made by various communities, and setting up standards which will assure that a high quality of service is offered to the chronic disease patient.

In New York State we have just established our first research center for investigation of this problem of chronic illness. It was brought about by a three-party arrangement among

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Grandma and Grandpa Live with Us

OLLIE A. RANDALL

Old age is inevitable, but accidents to the elderly are not.

THE PICTURE which this title immediately conjures up in one's mind is that of an elderly couple, feeble and in need of attentive, protective care. In reality we must keep in mind that nowadays the majority of grandparents are in the upper middle age brackets, with some in the lower range of those so-called middle years of life. Medical science and sanitary engineering—probably safety engineering, also—are combining forces to keep us alive much longer than was once the case, with the result that the family group is extending itself to include the fourth, and even the fifth, generation with much greater frequency.

In general the safety measures we need for grandma and grandpa are pretty much the same as those needed for people of all ages. A few special considerations are necessary for the really elderly folks, the great-grandparents, found both in family groups and living alone in furnished rooms, small apartments, or in small or large homes in villages and on farms scattered throughout the country. Some suggestions about attitudes may be as practical and helpful as more specific suggestions about safety devices and measures.

This subject is not academic. It is both real and timely. In our country we have a population of about 11,000,000 souls sixty-five years of age and over and almost 30,000,000 between the ages of forty-five and sixty-five. These numbers are not only large but they are increasing at a startlingly rapid rate. It is, then, simple enough to see that unless specific and direct attention is given to the potentiality for accidents inherent in this increasing proportion of older people serious consequences are bound to occur.

Miss Randall is consultant on services for the aged, Community Service Society of New York.

Risks of the Boarding Home

In large cities most families and individuals live in apartment houses or multiple dwellings. However, there are still a goodly number of the one- and two-family homes in which older people are subject to the particular hazards of stairs and fires which sweep so quickly through frame buildings. This housing accounts for the falls and burns which are the leading causes of accidental deaths and crippling illness. Unfortunately, nursing and boarding homes are often operated in these frame buildings. Such homes often are not or cannot be licensed. The combined shortages of hospital beds and housing have created a situation fraught with peril. Efforts to secure new licensing provisions requiring that these homes be made fire-resistive or fireproof are being made in almost every state in the union. Most of these homes are commercial ventures and their proprietors are either reluctant or unable to finance the necessary improvements. But almost any day in any large city there could be a holocaust similar to that which occurred last fall in upstate New York and early last winter in Iowa.

We need citizen support for enforcement

of rigid housing and fire protection measures. In the light of the possible danger such measures are not unreasonable. It seems medieval—it is at least Dickensian—that because the shortages are so great we are forced to make use of places which we know to be firetraps. This phase of the problem of old people "living with us" may seem to be irrelevant, but whether they are in our own homes or we have had to place them in homes in our community, they are indeed living with us and their plight deserves whatever help we can render. While our main hope lies in the fine caliber of the people now charged with dealing with this situation, no public servant, local or state, can reach his goal without the understanding support of his fellow citizens.

To go from the general to the particular, it might be well to point out that all old people are not alike. Yet they do have many characteristics in common. One is that they are apt to resent being protected or having special provision made for them although this is by no means invariably the case. If whatever is indicated is regarded as something useful to all members of the family group or to others in the household, there is much more likelihood of its being accepted as something useful and desirable by the older person. Since most old people do need help at one time or another, one occasionally yearns for the old days when young people were taught that it was good manners to help, or offer to help, the adults in the family. In groups where this still holds there is no singling out of the old for service which they sometimes must have but which they will too often resent if they suspect it is offered because they are "old."

Preventive Health Care

Those of us who have for years lived with older people are convinced that being constantly on guard about health is the best kind of accident prevention. Urging health examinations which detect the failing of faculties so that appropriate corrections can be made when either eyesight, hearing, muscular control, circulatory system, or even one's very bone structure is showing signs of wear and tear seems an obvious recommendation. But study of falls, many with disastrous results, shows it is at times difficult to determine whether an uncorrected or unadjusted physical condition induced the fall or whether the damage was done by the fall. Therefore, glasses, hearing aids, medication, and particularly nutritional therapy are all devices which are as preventive as they are corrective.

None of this is so simple as it sounds. It is very difficult to persuade many old people —and some who are not so old—to accept medical care. At times they are even more recalcitrant when it comes to using the remedies suggested or prescribed. Then too, funds are not always easily available. It is paradoxical but true that older people, while grimly holding on to life, will just as grimly hold on to their money in the bank or their insurance for burial purposes, but cannot be brought to use any of these resources, hoarded so carefully, for making life itself more tolerable and less dangerous. For these reasons it seems incumbent upon us who would have a healthier and safer world to live in to educate old people and their families as to the economy of health care on a regular basis. Casualties are expensive and risks should be avoided for old people who take at least three times as long to recover as younger people and are much more liable to sustain a permanent handicap.

Everyone needs education on the point so well made by Dr. Ernst Boas that "we must never take anything for granted with an older patient." It must never be assumed, he implies, that what is happening to an older person is logical and to be expected *because* of his age. Every symptom and evidence of frailty should have attention and careful exploration. If this change in attitude and in point of view about ailments in later years could take place more generally, it would be both constructively healthy and notably helpful in reducing the growing numbers of accidents both in the home and outside of it.

Safety in the Familiar

On the other hand, it is also important to remember not to impose upon older people

our own standards and thoughts about what is appropriate and satisfactory. Often, what seems unsafe to us in an older person's environment may not be so for him. There is a great deal to be said for familiarity with things and places as a preventive factor. The case of one woman who lived for a great many years in a second-floor "walk-up" apartment where every nook and corner and every piece of furniture were practically an extension of herself, so accustomed to all of it had she become, illustrates this point very well. Her eyesight failed, and in the earnest endeavor to do a good job a social worker with a conscience which made her worry over the little old lady insisted on moving her to a first-floor apartment where she would be "safe." On her second day in the new quarters, while feeling her way awkwardly around the unfamiliar place the little old lady fell and broke her hip! She might have done the same in the old place—but she was never convinced of that nor was I! And so, it seems to me that we should first hesitate and then move very cautiously in requiring changes of this kind, for safety can be a state of mind which overcomes physical obstacles, particularly if they are old enemies which have been faced so long as to seem almost friends!

Let me plead especially with those who have old people in their homes to be extremely careful and restrained about obeying that impulse to rearrange furniture. Old people have to get up much more often during the night than do younger people; and if the path to the bathroom has been changed by the shifting of furniture, even if it be left uncluttered, there can be more real danger to life and limb than in the deepest jungle!

Helpful Devices

The new luminous buttons for light switches and doorjambs give more confidence in moving about at night. The light bulbs in floor outlets are low-burning but constant guides in the dark. Luminous paint strips on the edges of stairsteps and touches of paint on the essential handrail help young and old when the house is spooky and dim with darkness.

What about that bathroom—which is fraught with danger at any time of day or night? There is the medicine chest which should always have a light over or near it and it is very helpful to have one of those small magnifying glasses so popular for reading telephone directories hanging within easy reach so that labels can be read without having to feel for the right bottle or return to another room for the forgotten glasses. Old people can make as many mistakes with medicines as children and need as much positive assistance as can be supplied. And for those glasses—can we all agree that the young woman who invented those spec-bands so that eyeglasses can be hung around one's neck and therefore be on hand whenever needed during the day, deserves a very special award of merit for what she has done not only for older people but for their families as well?

To return to the bathroom—the handrail by the tub, the rubber mats for it, and now the new substance which can be painted on the floor of the shower or on the bottom of the tub to prevent slipping are all "musts." I for one still prefer the old-fashioned bathtubs with the rim which can be grasped to the modern, streamlined molded-in-one tubs which look so elegant but are so dangerous. Bathtubs are a peculiar menace to old people. One could heartily wish that more of them might arrive at the degree of good sense of the crotchety old lady described in the amusing novel, "Mr. Skeffington." She had ordered her life with great satisfaction and had everything under control *except* the bathtub which presented such difficulty and such potential danger that she finally solved that difficulty by simply not using the thing at all!

It is understandable that we associate certain frailties with old age, and we may conclude that all old people suffering from similar frailties should be treated alike. For instance, if eyesight has failed or there is complete blindness it is usually thought that the same kind of protection is always needed. But it must be remembered that there is a great difference between the person who has been blind for many years and the old person

who is losing his sight due to his advancing years. The one has adjusted to his handicap, now static, so that in a sense it is no longer the same kind of handicap as that of the old person who is obliged to become used to progressively poor vision and old age at the same time. An old friend of mine taught me that lesson one day when I warned him about a low door—for he was exceptionally tall. He smiled at my warning and said, "My dear, you need never warn a tall man to watch out for his head. He has as a rule lived with his height so long that it's automatic for him to be on the lookout for low bridges!" And so, it seems that one safety measure is to know your grandma or grandpa! If lack of sight or hearing is of long standing there may be strengths and resilience and ability to meet the daily round of activities through habits formed during years of adjustment that become real assets upon which everyone can count for safety. If the loss of faculties comes late in life along with other physical changes, then there needs to be both physical and psychological support during the period of adaptation to these changes.

Even here let us bespeak understanding that with sympathetic help these newly handicapped older people can learn to overcome many of the difficulties such changes bring. Our new knowledge of medical rehabilitative technics opens exciting horizons for all of us, for the fact of advanced age no longer makes us accept as helpless and hopeless those situations once deemed to be just that. A glance at the list of devices available through the agencies for the blind and the deaf substantiates my belief that many of the devices supplied for special handicaps are very useful and suitable for people who are just old and whose sight or hearing may be slightly affected. This is true of orthopedic aids as well. "Mark timers" are a great help to anyone in preventing cooking accidents and have a greater usefulness for older people living alone. Yet here too the blind are away ahead of most of us with a special timer for the blind and deaf. It really seems that little has escaped their study. And there is small reason for not availing ourselves of what is already known.

Old People Have Judgment

At just this point in the twentieth century the longevity guaranteed to most of us is something of a mixed blessing. A great majority of our old people are far from well. Nevertheless the prospects of extending the vigorous middle years rather than merely spinning out the enfeebled ones are brighter as the months go by. It is encouraging to note the new emphasis on both physical and mental activity for older people which is found in our discussions and, more important, in our everyday experience. This means that each person must acquire a sense of responsibility for understanding his own physical capacity and its limitations. If an older person retains the mental ability to realize just how much he can do without serious harm to himself and just what chances he takes if he tries to do more than seems wise as a regular thing, it seems desirable that he should decide just when and how he will take such risks. This needs to be stressed for families must not be overprotective—a negative way of caring for older people. There should be no necessity for keeping old people housebound because of the bare possibility of a heart attack on the street from overexertion, provided the old people know the risk and want to take it.

Our recreational centers are proving to us that old folks are cautious and careful and that if the motivation is sufficiently strong they will battle the elements and seemingly insuperable physical obstacles with little or no harm to themselves. A group of them at one of the day centers were asked for suggestions as to safety devices they wished to have recommended at a safety council meeting. From men and women whose average age was seventy-five there was not a single suggestion for a device related to making home a safe place to *stay*. Every proposal had to do with making it easier for them to negotiate uneven pavements, icy streets and steps, and buses in busy parts of the city. With more and more old people among us these measures are going to be needed, for we certainly cannot plan to keep 10 percent and more of our city's residents homebound and inactive. Such an idea is unthinkable.

Our Tempo Is Too Fast

The tempo of city life is perhaps harder for older people than anything else. If we could begin an educational campaign to make people realize that more and more of us would appreciate an adjustment of some of our public services to a slackening pace, life might be much more comfortable for everybody. If a rule could be made compelling bus drivers to wait for old people (and some of us not so old) to be seated before starting off with such a jerk that everyone in the bus is thrown about, travel might be safer for all of us. If buses would stop at the curb and be more careful about doors, many accidents to older people might be prevented. In my apartment house where there are some sixty old people the greatest number of accidents have come from such bus situations. And there is seldom any redress for the confused old person who is usually precipitated into a state of shock by what has happened so the facts are seldom clear. We have already had numerous suggestions for lengthening the intervals between traffic signals for the safety of pedestrians, just as we have specially timed the closing of the self-service elevator doors in the house in which I live.

Children's playgrounds are so hazardous for old people that they should always be avoided by those who are the least bit unsteady or frail. Roller skaters and baseball or basketball players can wreak great havoc with them. In spite of an intellectual belief in keeping old and young together as much as possible experience is bringing a firm conviction that activity in parks for older people should be planned so that it can take place segregated from that of children or active young adults. At our house elderly residents are now warned about children in the park and the playground across the way as regularly as they are about ice, snow, and wind which can buffet old folks around unmercifully.

These are just a few of the facets of the safety problem for older people who live with us. The specific suggestions as to what can be done within the home have been made by others, including Lillian Gilbreth, consulting engineer, and the Home Accident Prevention Services of the American Red Cross. But one idea which may have merit in other communities has been suggested by the New York State Safety Council to the New York State Joint Legislative Committee on Problems of the Aging: that there would be real profit in planning in any community an educational campaign, a "Safety Week for the Elderly." In this way we might discover something more about accidents which are not reported as a general rule, acquire new knowledge of ways and means to prevent them, and succeed in creating a different attitude toward the enemy of old people and their families—the home accident.

Old age is inevitable but accidents in old age are not. When we accept that as a premise upon which to predicate our efforts, we shall have taken a major step toward a healthier and more satisfying home life and a higher level of public health.

This article is based on a talk given at a meeting of the Greater New York Safety Council.

It's Fun to Teach Health in Other Countries

Verna G. Smith, R.N.

She bathes daily to wash off the perspiration and its poisons. Her skin throws off part of the baby's waste. Keeping clean will help her to feel cool and comfortable.

Siya ay maliligo araw-araw upang malinis ang kanyang katawan, at ng mahugasan ang kanyang katawan ng pawis at ng lason ng katawan. Sa kanyang balat lumalabas ang isang bahagi ng dumi ng bata. Ang pagiging malinis ay nagdudulot sa kanya ng kaginhawahan at kalamigan.

EVERY PUBLIC HEALTH nurse has a little of missionary zeal, else she wouldn't have chosen her particular profession. Perhaps I had a little more than usual because I became a missionary nurse to another country —the Philippines. My first two summers here I have had the good fortune to teach in a six weeks' summer school camp for church young people of Southern Luzon. The students were of both sexes, single and married, and there were some not so young. The teaching emphasized maternal and infant care with additional instruction in nutrition, first aid, and care of the sick. I have not seen this kind of thing done in the churches in the states.

The 130 young people were divided into sections. Each group received two to three hours per week of instruction, depending upon the educational background of its members. Wherever possible the teaching was done by demonstration. For instance, one year my own baby was a cooperative and fitting subject for the baby bath. One who teaches health in a foreign country is bound to learn as much as her students—about the culture of the country and its prevailing customs. Or she may learn how different one section is from others in language, eating habits, and so forth. I learned to admire the students for their frank questions and their desire to learn.

Some of the questions they asked were: Will sour (citrus) fruits eaten during the menstrual period coagulate the blood? If we eat twin bananas before we are married will we have twins? Will it not hurt to have so much air around the baby during the bath? Why is it that sometimes after the baby is delivered the midwife will not let the mother go to sleep because she is afraid the mother will die in her sleep? Why is it some pregnant mothers will not eat meat? Will it not decrease the baby's blood if he is bathed in the afternoon? Why is it that a baby with fever cannot be given water to drink? We tried to discuss each question thoroughly.

After their final examination the students were asked to write a short paragraph about what they considered most valuable in the course. One wrote: "I learned that by nature the baby and the placenta are born when it's their time to be born, so I'll advise the midwife that took care of my mother and caused a baby to be born dead, that it is not wise and advisable to push a baby out."

Out of this teaching background and with the encouragement of the director of audio-visual production (who is my husband) and the principal of the summer schools, I began to prepare health literature. Our first pam-

phlet is called "Baby Is Coming." It has been reproduced in strip film and shown in a number of places in the Philippines. We have tried to gear our productions to the culture and needs of the country as you see from the sample page illustrated here.

The success of this first booklet has been most gratifying. These young people are so appreciative of everything done to help them that they stimulate us, their friends and teachers, to our greatest efforts. Now we are at work on the second publication, "Baby Is Here."

Yes, it's hard work but it's fun too, to teach health—especially in a land with so bright a future.

Certification of School Nurses

NEW JERSEY

The following revised rules for the certification of school nurses were adopted by the New Jersey State Board of Education in October 1950:*

Requirements

1. High school graduation or equivalent attainment
2. Graduation from an approved school of nursing
3. Registration as a nurse in New Jersey
4. One year of experience as a registered nurse, or graduation from an accredited college
5. Completion of a minimum total of twelve semester-hour credits with work in each of the fields listed below in a college approved by the New Jersey State Board of Education:
   a. School nursing including such areas as organization and administration of school health services and school health problems
   b. Child growth and development: mental, emotional, social, and physical
   c. Methods and materials in teaching including such areas as methods and materials for teaching, child development and care, nutrition, home nursing, safety, and first aid
   d. Public school curriculum including such areas as curriculum building in health and nutrition
   e. Sociology including such areas as applied sociology, family casework, and education for family living
   f. Public health including such areas as public health nursing, community health problems, and communicable disease control.

Term

The limited certificate may be made permanent when the applicant completes:

1. Three years of successful experience as a school nurse
2. Completion of a minimum total of eighteen semester-hour credits with work in each of the fields listed below in a college approved by the New Jersey State Board of Education:
   a. School nursing including such areas as organization and administration of school health services, and school health problems
   b. Child growth and development including such areas as psychology of learning, human growth and development, adolescent psychology, educational measurements, and mental hygiene
   c. Methods and materials in health education including such areas as personal hygiene, anatomy and physiology, community health, safety, first aid, home nursing, child development and care, and nutrition
   d. Sociology including such areas as applied sociology, family casework, and education for family living
   e. Public school curriculum including such areas as curriculum building in health, nutrition, and safety
   f. Special health problems in education including such areas as vision conservation; hearing conservation; dental health; prevention and control of tuberculosis and other communicable diseases; and care, health supervision, and education of handicapped or exceptional children.

TEXAS

The Committee for the Improvement of School Nursing Service of the Texas SOPHN participated in a cooperative workshop on teacher certification and professional standards in the summer of 1950. The other groups represented in the workshop were the Texas Education Agency, Texas State Teachers Association, Texas Vocational Education Council.

* This regulation is not retroactive and does not apply to school nurses employed previous to its adoption.

Proposed standards for school nurse certification were set up. These are to be given further study. They are printed here for general interest and to indicate trends and progress in the area of certification of nurses in school services.

School nurse

To receive the provisional certificate to serve as nurse in the public schools, it is recommended that the applicant meet the following requirements:

1. Shall have completed training as a registered nurse covering three years' work in an approved program of nursing
2. Shall have current registration as a nurse in Texas
3. Shall have completed a minimum of thirty additional semester hours of work in approved programs of:
   a. Public health nursing, including the field of nursing in the school health program
   b. Professional courses in education, including those areas stipulated by the state accrediting agency as basic for all professional personnel working in public schools.

To receive the standard certificate to serve as school nurse, the candidate shall have completed a fifth year or more of college work in an approved program culminating in a bachelor's degree with a major in the field of specialty and fully complying with the requirements in general and professional education set up for other school personnel.

WISCONSIN

In 1949 a committee representing the state departments of public instruction and of health and the board of nurse examiners established standards for the certification of school nurses.

Provisions are made for issuing both the limited and permanent certificate. To receive the former a nurse must be a high school graduate or its equivalent, eligible for university matriculation, a graduate of an approved school of nursing and eligible for state registration, employed in Wisconsin, and must have not less than fifteen semester hours of credit in an approved course in public health nursing. The permanent certificate is based on the above qualifications plus the completion of not less than one academic year in an approved course in public health nursing within three years of employment.

WHERE ARE THEY NOW?

If you know the present address of any of the following individuals, will you please send a postcard with this information to NOPHN headquarters so that we may bring our records up to date? Last known addresses are given here.

ARIZONA
Bilyeu, Lillian—Moon Vista Apts., Yuma

COLORADO
Saterberg, Mrs. Ethel, 659 Cherokee, Denver 4

CONNECTICUT
Kamerzel, Mary J., 29 South Main Street, Branford

GEORGIA
Nicholson, Battey, Chatham-Savannah Health Council, 23 E. Charlton Street, Savannah

ILLINOIS
Donlin, Grace, 442 Deming Place, Chicago 14

INDIANA
Culler, Eileen M., 1718 St. Joe Blvd., Ft. Wayne
Hatfield, Catherine, 807 Atwater Avenue, Bloomington

MASSACHUSETTS
Aldrich, Mildred, Holyoke Nurses Association, Holyoke
Tracy, Mrs. Gladys W., 40 Rockview Street, Jamaica Plain

MICHIGAN
Brenner, Anita G., 9743 Martindale, Detroit 4
Clatworthy, Pearl, 15768 Wisconsin, Detroit 21
Forrest, Mrs. Eloise, 3961 Weddel, Dearborn
Logan, Eva, Department of Health, Detroit 1
McCarthy, Mrs. Genevieve G., 6851 Bingham, Dearborn
Opperman, Nina, 18017 Murray Hill, Detroit 35

MINNESOTA
Beasley, Florence A., University of Minnesota, 351 Sanford Hall, Minneapolis
Fink, LaRue, Public Health Nursing Service, Rochester
Kurth, Marillyn R., 1317 E. 2 Street, Duluth

MISSOURI
Couste, Mrs. Juanita S., 715 E. 9 Street, Kansas City 6

(Continued on page 54)

Priorities in Public Health Nursing Education

A Statement of Recommendations by the NOPHN Education Committee

REALISTIC PLANNING for public health nursing education must be based upon facilities and needs. Resources and facilities for public health nursing education lie in two main areas: (1) universities and colleges and (2) agencies administering public health nursing services. When demands are numerous and facilities limited, priorities must be defined in order that long-range goals may not be lost sight of while immediate objectives are being achieved.

The first and most pressing need is the service need—the need for well qualified public health nurses to fill current periodic vacancies and newly created positions and replacements in public health nursing services. Other demands—constantly increasing demands—upon public health nursing educational resources lie in the areas of total nursing education (not necessarily education of the specialist in public health nursing) and the education of related health professions, such as medicine, public health, dentistry, and nutrition.

Recommendations for the Development of University Facilities for Public Health Nursing Education

Let us look first at priorities in relation to the resources and facilities of universities. From 1912 until 1945 public health nurses in community groups and through their professional associations encouraged the development of educational programs for graduate nurses to prepare them to work in beginning public health nurse positions in public health nursing services. During that time forty-four universities responded to the demands and established programs of this type. The peaks of development occurred in two separate ten-year periods. The first was from 1912 to 1922 when sixteen programs received recognition by the National Organization for Public Health Nursing, and the second was from 1935 to 1945 when twenty-four programs were accredited by the NOPHN. Not all of the programs established since 1912 have survived; nine have been permanently discontinued and three were discontinued for a period of from five to twenty years.

The programs were discontinued in all probability because of one or more of the following factors: lack of well qualified faculty, failure to attract students, financial limitations. Such a record raises several questions: Were too many programs established? Have there been times when it was not possible to maintain that number of good programs in the United States? Might the facilities of some universities have been developed more constructively to meet other needs in nursing education?

Looking at the problem from another aspect reveals some interesting facts. Even though sincere efforts have gone into this type of education for many years and although it accounts for the preparation of the largest number of nurses who qualify for public health nursing positions, only one third of the nurses employed in public health nursing services have completed a year or more of the recommended preparation. One would conclude that, although the education is available, graduate nurses are not able, for some reason, to secure the benefits of such education. The basic problem, therefore, is prob-

ably economic—a fact which was constantly borne out when enrollments increased in these programs as graduate nurses were able to pursue further education by virtue of financial benefits which were made available under the Social Security Act and the G.I. Bill of Rights.

The question is often asked, do we need more of these programs? In 1945 the NOPHN Committee on Accreditation stated its belief that there was no need to encourage the development of additional educational programs in public health nursing for the preparation of graduate nurses for beginning public health nurse positions. It was not possible at that time for universities to secure a sufficient number of public health nurses who held the qualifications recommended by the NOPHN for the directorship of such a program. (See "Recommended Qualifications for Public Health Nursing Personnel, 1940-1945" and "Recommended Qualifications: An Interim Report by the Committee for Revision." See also "Recommended Qualifications for Public Health Nursing Faculty and Teaching Personnel.") There had been a great problem, too, in securing adequate facilities for field instruction and training to meet the demands of the already established educational programs in public health nursing.

Today the same position is valid. Anyone who has been associated with a university conducting educational programs in nursing for which public health nurse faculty is needed knows that there is a dearth of such qualified personnel. Fulltime enrollments appear to be decreasing and this trend will probably continue unless and until some form of scholarship aid is available for large numbers of graduate nurses who are interested in securing university preparation for public health nursing. Additional satisfactory field resources are not available in sufficient quantity to provide the lengthy period of field instruction which is an essential part of this particular educational pattern.

The NOPHN Education Committee, therefore, reaffirms today the position that additional university programs in public health nursing for the preparation of graduate nurses for beginning public health nurse positions in public health nursing services should not be developed.

Scholarships and other aid needed

Action becomes necessary when the balance between needs and resources cannot be maintained. Sometimes such action brings to certain groups and sections of the country problems which must be solved through concerted action. It is recognized that many public health nurses without special preparation are located in sections of the United States where approved university programs in public health nursing are not established. There are, however, distributed widely throughout the United States 1,808 institutions of higher education. Through these resources graduate nurses may secure instruction in general educational subjects which are either prerequisite to or are a part of approved professional programs for public health nurses. These are usually courses leading to the development of communication skills and courses in psychology, sociology, and pedagogy. Even if this general academic preparation can be secured locally, the problem of professional instruction still remains. It then becomes a challenge to those interested in public health nursing to aid graduate nurses to obtain the necessary scholarships, leaves of absence, and other assistance which will enable them to secure the education for public health nursing in the universities where it is now offered.

In various sections of the United States universities might find it necessary to do some pooling of resources, some shifting of emphasis, extramural activities, and experimentation in public health nursing education if they are to meet the needs of the nurse who has entered the field of public health nursing without the full preparation required to perform her work. Perhaps this can best be accomplished through regional planning for public health nursing in which nursing groups, universities, and others interested in this problem unite.

Collegiate basic programs a priority

The NOPHN Education Committee has stated its belief that collegiate basic education

is a new priority in university education in preparing personnel for beginning public health nurse positions under supervision in public health nursing services.

If the interest of universities in public health nursing education can be secured, might it not be well to urge universities to make their resources and facilities available for the establishment of collegiate basic programs whose graduates are ready, without further formal education, to enter the field of public health nursing? Would not employers welcome the opportunity to recruit larger numbers of these nurses who would not have to interrupt their service responsibilities to supplement lacks in their preparation?

If recognition is given to collegiate basic nursing education as a priority in the university today, the university that establishes or conducts such a program and also has an approved educational program in public health nursing for graduate nurses is in a unique position. The faculty and the resources of the latter program are already available to assist in helping those responsible for the basic program to accomplish one of its objectives, namely, the preparation of nurses for beginning public health nurse positions under supervision in public health nursing services.

One of the sections of the NOPHN, the Collegiate Council on Public Health Nursing Education, has recorded its willingness to further collegiate basic nursing education, especially where such education will prepare public health nurses of the future. The membership of the Collegiate Council consists of the fulltime public health nurse faculty members who are teaching in educational programs approved for public health nursing. The Council possesses the type of leadership which has brought public health nursing education to its present state of development and it could also be a potent force in implementing this new priority in education for professional responsibilities in nursing.

Priorities for Public Health Nursing Services

It was pointed out earlier that any system of priorities should be oriented to service needs. If this is true, public health nursing services should make their facilities for field instruction available first to those groups who because of such instruction will at once increase the number of qualified nurses in public health nursing services. Previous statements of priorities published by the NOPHN have emphasized this principle. (See "Selection of Students for Affiliation in Public Health Nursing," PUBLIC HEALTH NURSING, April 1939, pages 204-205, and "Priorities in Field Training Opportunities in Public Health Nursing," PUBLIC HEALTH NURSING, September 1947, pages 472-473.)

After a thorough review of the problem the Education Committee of the NOPHN recommended to the NOPHN Board of Directors in January 1950 that the following priority groups be established for supervised field instruction in public health nursing services:

Students in approved programs

Students enrolled in educational programs in nursing approved for public health nursing by the National Nursing Accrediting Service. These include: (1) university programs preparing graduate nurses for beginning public health nurse positions in public health nursing services and (2) collegiate basic programs which prepare nurses for beginning public health nurse positions under supervision in public health nursing services.

Other collegiate students

Students enrolled in collegiate programs in nursing (not yet approved for public health nursing by the National Nursing Accrediting Service) which have as one of their stated objectives the preparation of nurses for beginning public health nurse positions under supervision in public health nursing services. The schools are taking steps to accomplish this purpose.

Faculty and prospective faculty

Nursing faculty teaching in the above collegiate schools of nursing and graduate nurse students in universities who are preparing themselves for faculty positions in collegiate programs.

It was also recommended that public health nursing services which have the facilities engage in experimentation in field instruction of students enrolled in schools of practical nursing provided those schools are accredited by the National Association of Practical Nurse Education or by the appropriate body in the state in which the school is located.

Universities have within their borders the resources to develop the essential theory which gives the student certain knowledge and understandings. In order to learn how to give public health nursing care to families in the home, in school, at work, and in the community, realistic learning experiences must be provided in the type of agency that renders such service to the community. Public health nursing services provide the setting in which such direct instruction may take place. To date no other acceptable substitute has been discovered for the satisfactory development of the abilities needed to begin to fulfill the responsibilities inherent in public health nurse positions in public health nursing services.

Resources for field instruction in public health nursing services are not available in proportion to the demands that are made upon them. Therefore these facilities must be reserved for those students and nurses (1) who are best prepared to participate in and benefit by such an educational experience (2) who will be able to apply their knowledge in their own setting in a manner that will aid in achieving the objectives of public health and meeting the service needs for public health nursing in the community.

Students in approved programs

Approved university programs in public health nursing which prepare graduate nurses for beginning public health nurse positions in public health nursing services require approximately 640 clock hours of supervised field instruction in a public health nursing service. This amounts usually to a four-month period. In some instances it is given concurrently with theoretical instruction; more frequently it is given in a block of instruction. Very often the field instruction is a terminal experience in the educational program and the nurse is immediately available for a position in a public health nursing service. This period of field instruction is based upon the realization that the most effective way to prepare the public health nurse practitioner is through an interrelated curriculum of theory and practice. The length of time (four months) is that considered by universities and agencies working together for the public health nursing education of graduate nurses to be of sufficient duration to accomplish the objectives stated in "The Public Health Nursing Curriculum Guide,"* Part Eight, "Field Experience." The time requirement is specified in the criteria established by the NOPHN for this type of education. (See "Essential Requirements for Programs of Study in Public Health Nursing for Graduate Nurses Preparing for First Level Staff Nurse Positions," available from the NOPHN and published in the *Manual of Accrediting Educational Programs in Nursing*.) In recent years there has been some experimentation with respect to time, content, and method in providing this essential experience.

Approved collegiate basic nursing programs require at the present time at least two months (eight weeks) of supervised field instruction in a public health nursing service. In fact, this experience is one of the conditions necessary for such a program to qualify for accreditation for public health nursing. (See "Criteria for Collegiate Basic Professional Programs Designed to Prepare Their Graduates for First Level Positions in Public Health Nursing under Supervision," available from the NOPHN and published in the *Manual of Accrediting Educational Programs in Nursing*.) Field instruction, moreover, is usually one of the culminating experiences in the basic student's total educational program. During the senior part of her clinical experience the student is rotated to supervised field instruction in a public health nursing service.

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* Joint Committee of the National Organization for Public Health Nursing and the United States Public Health Service. The public health nursing curriculum guide. N. Y., National Organization for Public Health Nursing, 1942. 206 p. $2.

Although the number of collegiate basic nursing programs approved for public health nursing is small (see "Programs of Study for the Preparation of Public Health Nurses") variations do occur in the length of time provided for field instruction. In one school the period extends over a university quarter, of twelve weeks; in another two additional months of field instruction are offered to students on an elective basis. Integrated throughout the entire nursing curriculum are selected observations and other learning experiences which are provided by and in public health nursing services.

If the objectives of these collegiate basic programs are achieved, the students assigned to public health nursing services for supervised field instruction are well grounded in the clinical aspects of nursing. They have a sound foundation in the social sciences that are basic to an understanding of human relations and social needs. Intertwined and interwoven throughout nursing and other subjects they have studied is the concept of health—its meaning, its significance, how it is achieved, how it is preserved, how persons are restored to a favorable state of health after illness and how they are rehabilitated into family life and into the pursuits of the community. They have had instruction regarding the concepts and principles of public health nursing.

Some knowledge of how public health is organized in a community is also a part of their equipment when they begin their experience in a public health nursing service. There is no need at that time to introduce them to the health information essential for teaching people and their families the way to health. There is no need to acquaint them with the patterns of disorganization of family and community life and the underlying philosophy behind the multiplicity of social and health agencies that society has developed to meet some of the fundamental human needs. They appreciate the meaning of teamwork and the interdependency of various professional workers and the need for them all to work together for the maintenance of family and community well-being. They are aware of the many ramifications—emotional, health, and social—arising from the illness of one member of the family unit. They sense the public health significance of widespread illness or death in the community. They know in general what facilities and resources might be marshalled and brought into play toward the reduction and elimination of hazards to healthful living in family groups, in school groups, in work groups, and in the community at large.

With some introduction to the specifics in a given public health service and a given community, these students can be guided in their management of selected families and in performing the daily duties of the beginning practitioner in public health nursing. They develop the skills of this practitioner. They gain increasing competence and understanding of public health nursing activities through the planned conferences and supervision which accompany their experiences in this setting.

For the student, supervised field instruction provides an opportunity for a vocational tryout in a field somewhat different from the hospital setting in which much of her other learning in nursing has been secured. For the public health nursing service the recruitment possibilities are numerous—are, in fact, in direct proportion to the number of such students accepted for education of this type.

Other collegiate students

The counterparts of the students described above are found in various stages of development in other collegiate basic schools of nursing. As new collegiate programs in nursing are established their numbers will increase. Frequently the development of these programs is handicapped by only two lacks—lacks which the field of public health nursing can meet. One is the lack of a well qualified public health nurse faculty member on the staff of the school of nursing. (See faculty qualifications as stated in "Criteria for Collegiate Basic Professional Programs Designed to Prepare Their Graduates for First Level Positions in Public Health Nursing under Supervision" and in "Recommended Qualifications for Public Health Nursing Faculty and Teaching Personnel.") The other is the lack of supervised field instruction in a public

health nursing service. It is wasteful indeed for graduates of these collegiate programs to have to spend additional time in preparing themselves for beginning public health nurse positions when the initial period of time required for completion of a collegiate nursing program could have made them eligible for beginning positions under supervision in public health nursing services.

We in public health nursing have not done enough if we have offered students in collegiate professional programs in nursing only occasional visits with public health nurses or short periods of observation and practice. This group is a priority group that needs supervised field instruction in a public health nursing service for a minimum period of two months (eight weeks).

Faculty and prospective faculty

The education of the nurse who will meet the service needs in public health nursing begins as soon as she decides to enroll in an educational program in nursing leading toward her professional preparation. Every faculty member who guides the student's learning experiences is consciously or unconsciously helping the student to develop certain understandings, abilities, and skills which will enable her later to fulfill nursing responsibilities in public health nursing services. The scope of human needs and their significance, and the experiences in the field of public health nursing required to answer these needs are unknown to many of the nurse faculty members who are teaching in collegiate basic schools of nursing today. Some graduate nurses who are preparing through university education for faculty positions in collegiate programs have not had educational or work experiences in public health nursing. If agencies would offer this group supervised field instruction, these nurses would be better prepared to give their students some of the understandings basic to the development of a public health nursing point of view. The length of this experience for faculty members or prospective faculty members of collegiate schools of nursing will vary depending upon the previous experience of these nurses, their needs, and the conditions under which it is possible for them to accept such instruction and guided experience. The time, however, should not be so short that its purposes are not achieved or the experiment is meaningless.

Summary

Any plan for the selection of students for supervised field instruction in public health nursing services should be directed toward increasing the supply of nurses who, upon completion of an educational program, are qualified to fill positions in public health nursing services. This statement of priorities has been developed with this purpose in mind.

Field instruction should be planned as a part of a total educational pattern. At the time a student or graduate nurse presents herself for this experience, the public health nursing service cannot give her the theoretical instruction and other basic experiences that are inherent in the health and social aspects of nursing. These are prerequisite to field instruction and can and should be learned elsewhere.

This current statement of priorities introduces nothing new in the way of principles or concepts. Students enrolled in approved educational programs which prepare nurses for beginning public health nurse positions in public health nursing services have always been in the priority groups. (See "Selection of Students for Affiliation" and "Priorities in Field Training Opportunities in Public Health Nursing.") Students enrolled in schools of nursing that are able to provide the more comprehensive type of nursing education were included in the priority groups in 1939. (See "Selection of Students for Affiliation.") Today it is recognized that the university or college, all other things being equal, has the most satisfactory resources and facilities for providing the most comprehensive type of nursing education desirable for the nurse who will carry out public health nursing responsibilities.

Faculty and teaching personnel in schools of nursing have traditionally been considered in the priority groups, and yet public health nursing facilities have been used least frequently for these nurses. (See "Selection of

Students for Affiliation" and "Priorities in Field Training Opportunities in Public Health Nursing.") Perhaps there may be periods when faculty in collegiate basic schools of nursing could be released for this purpose. Certainly field placements in public health nursing services could be planned as part of the educational program for graduate nurses enrolled in university programs designed to prepare faculty for collegiate education in nursing.

More successful implementation of priorities is needed. This will require a closer working relationship between the university and other collegiate institutions and public health nursing services. Leadership may come from either direction. Sound educational motives rather than personal feelings or capitulation to pressure should be the guiding factor in the selection of students and faculty for supervised field instruction in public health nursing services.

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A Forty-Year Demonstration of Public Health Nursing by the Metropolitan Life Insurance Company

DONALD B. ARMSTRONG, M.D.
ALMA C. HAUPT, R.N.

A DEMONSTRATION is defined as "a method of showing that from given premises certain results must follow." We are not generally accustomed to thinking of a program that lasts for more than forty years as a demonstration. However, when Leroy A. Lincoln, president of the Metropolitan Life Insurance Company, made public the company's decision to terminate its nursing service by January 1, 1953, he announced the successful conclusion of such a demonstration. Few people have considered the company's program in that light because it has become so much a part of the total public health nursing movement.

The nursing service has always been an extra privilege extended to Metropolitan policyholders who lived where service was available; it was never a part of the insurance contract between the company and its policyholders. Even in the early days of the service, its successful termination was anticipated. Dr. Lee K. Frankel, who first directed the programs of the Welfare Division, is reported to have said repeatedly to groups of nursing personnel, "We must all cooperate in order to work ourselves out of a job; then we shall know that our efforts have been constructive and our results accomplished."

Let us look again at the definition of a demonstration and see how Metropolitan Nursing Service fits into it. What were the premises when the service was started in 1909 and what are the results in 1950?

Dr. Armstrong is second vice-president and Miss Haupt is director of the Nursing Bureau of the Health and Welfare Division, Metropolitan Life Insurance Company.

How MLI Nursing Service Began

In the early 1900's the workingmen and their families who made up the bulk of Metropolitan's industrial policyholders were lagging behind the rest of the country's population in health and longevity. In 1909 the company established a Welfare Division to bring to these policyholders knowledge of what could be done to control the diseases which were taking a heavy toll of life and health. The company's agents took into the homes they visited regularly health pamphlets containing lifesaving information. Appropriately, it was Lillian D. Wald of New York's famous Henry Street Visiting Nurse Service who told Dr. Frankel: "There is a need among your policyholders which neither the agents nor your pamphlets can fill. That need is for visiting nurse service for the sick."

As a result of her suggestion nursing service was begun for a three-month trial period in one section of Manhattan. The visits were made by Henry Street nurses at a cost to the company of fifty cents per visit. The value of this service quickly became apparent. A study of pneumonia patients, for which, unfortunately, no record is available, showed that those who had nursing service recovered faster than those who did not. The tremendous need for nursing care was clear long be-

fore the trial period was over, and Metropolitan decided to extend the service to other cities immediately and in 1910 to Canada.

Achievements of the Service

Wherever standards permitted, existing local nursing organizations were used. Where no appropriate agency was available the company employed its own salaried nurses. Especially for urban communities this proved to be a tremendous incentive for expansion of service. Many towns received their first demonstration of the value of visiting nurse service from the work of the Metropolitan nurse and were encouraged to establish their own community services.

Visiting nurse service was established to show that nursing care could help to prevent sickness and premature death. It has done this in many ways. It has helped the sick to recover earlier and get back on their feet sooner than they might otherwise have done. It has helped patients with chronic disease and their families make longterm plans for recovery and for appropriate use of community facilities. In the course of these accomplishments the Metropolitan has paid $106,000,000 for its nursing service from 1909 through 1949. This is no doubt the largest single amount paid by any one voluntary nursing organization. Now the picture changes. Some of the developments in MLI nursing service over the years are given in Table 1.

Among the factors which have helped to bring about these changes are increased hospitalization, more public health facilities, new therapeutic procedures, early ambulation for surgical and maternity cases, health education of the general public, and an increase in coverage by medical care plans. As a result, the chief future needs for bedside care seem to be among the chronically ill, a group to which the Metropolitan has been offering limited service for a maximum of six visits per case.

Ability to Pay Has Increased

Dr. Louis I. Dublin, second vice-president and statistician of the company, has pointed out that in 1909 the average earnings of industrial policyholders were approximately $15 or $16 a week. At the present time they are more than four times that. In spite of the increased cost of living the whole economic status of industrial workers and their families has immeasurably improved. Therefore, industrial policyholders have greater ability to pay for nursing service now than they had when the service was started by the company. Statistics collected since 1933 show a fairly consistent downward trend in the number of visits made by both the salaried nurses and the VNA staffs to Metropolitan policyholders.

MLI NURSING SERVICE
COMPARISON OF TYPES OF CONDITIONS FOR WHICH NURSING SERVICE WAS GIVEN IN 1929 AND 1949

Conditions	1949* (percentage)	1929* (percentage)	Change in Percentage
Total	100.0	100.0	
Acute and communicable	16.2	48.7	−32.5
Chronic conditions	17.9	5.1	+12.8
Newborn	25.1	14.9	+10.2
Maternity	27.5	21.1	+ 6.4
Injuries and others	13.3	10.2	+ 3.1

* Percent distribution of conditions for which policyholders received nursing care.

Health Education Will Continue

As MLI has announced earlier, the Health and Welfare Division will maintain its health education program with such new emphases and modifications as may be indicated from time to time. Appropriate company pamphlets, posters, exhibits, motion pictures, and films will continue to be made available to nursing groups. As in the past, we shall count on the valued cooperation of nurses in visiting nurse associations, health departments, schools, and industry in the use of our materials for the improvement of the health of the public. Suitable material will also be made available to faculty and students in schools of nursing and university programs of study in public health nursing.

Following Mr. Lincoln's announcement of the discontinuance of the Metropolitan Nursing Service by 1953, we received many letters from affiliated nursing services and other

agencies. They express surprise, regret, appreciation, and understanding. Many have mentioned the Metropolitan's contribution to public health nursing over the past forty years through the extension of bedside nursing care, through financial support for the nursing movement, and through the promotion of higher standards of service. It has been gratifying to hear how valuable the visits of the company's territorial nursing supervisors have been.

The company wishes to express its thanks for the understanding attitude manifested. It expects to aid in every feasible way to make the transition period up to 1953 contribute as much as possible toward the development of adequate and permanent community nursing facilities.

Easing the Transition

We should like to report on a number of steps already taken:

1. Helen Snow, area supervisor, and Marjorie Adams and Judith Wallin, territorial supervisors, have been loaned to the NOPHN to give field service to communities where we have had Metropolitan salaried nurses and where there is need to strengthen a visiting nurse service or start a new one. In addition, a financial grant has been made to the NOPHN for related secretarial assistance and travel.

2. Helen Connors, a territorial supervisor, has been loaned to the NOPHN to act as secretary of the joint Committee of the ANA and NOPHN on Nursing in Medical Care Plans.

3. A conference on community organization for public health nursing has been conducted by Ruth Fisher and Dorothy Rusby of the NOPHN staff for the benefit of our territorial nursing supervisors.

4. Conferences have been held with representatives of Community Chests and Councils of America, Inc., which resulted in:

(a) The distribution by Community Chests and Councils of Mr. Lincoln's announcement with a covering letter to all local chests concerned.

(b) The offer of Community Chests and Councils to keep local chests and councils currently advised of developments.

(c) Experimentation, under the direction of a NOPHN committee, with a method to determine the probable reduction in visiting nurse association caseload and income as a result of the withdrawal of MLI contracts. The Visiting Nurse Society of Philadelphia and the Visiting Nurse Service of New York are cooperating in pilot studies on this subject, and as soon as results are available they will be announced.

Calling for special attention are the 185 communities in the United States where we have employed about 300 Metropolitan nurses because there was no appropriate agency with which to affiliate. It is largely to help these communities develop adequate public health nursing service that the company has entered into the new cooperative arrangements with the NOPHN. After careful study of these salaried nurse centers forty have been referred to the NOPHN for advisory service. Other centers in the Pacific Coast Territory will be added later. The 145 remaining centers will be visited by our Metropolitan territorial supervisors.

The company is also making every effort to assist its salaried nurses through a generous revision of the retirement program, separation allowances, and professional counseling by members of the Nursing Bureau staff. The home office territorial supervisory staff has now been reduced from ten to five, three through loan to the NOPHN and two through resignation for challenging new assignments. Therefore, the area of each of the remaining supervisors has been greatly enlarged to encompass the big job that lies ahead.

Obviously it will no longer be possible to keep up our regular territorial supervisory visits to affiliated agencies, but we hope that the NOPHN may continue a comparable service on a regional basis. However, within the limits of our home office and head office staffs we will try to meet requests of agencies for field service and to give such aid as is possible through correspondence and attendance

at national, regional, state, or local meetings. Provision of our health education materials will continue as in the past.

Working together with the NOPHN and other agencies, we hope that this decision to terminate our service and close this forty-year-old demonstration will be a new milestone in the progress of public health nursing, a cause which commands the full devotion of all of us.

A Joint Attack upon Chronic Disease

(Continued from page 25)

national, state, and local agencies. The U. S. Public Health Service has made available the facilities formerly occupied by the Buffalo Marine Hospital. These consist of a seventy-five-bed hospital plus four auxiliary buildings which are suitable for outpatient services or convalescent care. The state, through the Department of Health, is providing the necessary funds. The University of Buffalo, through its College of Medicine, is taking the responsibility for operating the hospital and directing the research. The hospital is known as the Chronic Disease Research Institute and will conduct investigations directed at the development of improved methods of prevention, diagnosis, treatment, and rehabilitation in chronic disease. Among the special projects will be a rehabilitation center for patients suffering from chronic alcoholism, a rehabilitation unit, and a multiple disease screening unit.

In the future we hope there will be other centers of this type in New York and in other states. New methods and technics, developed through concentrated research supported by all interested agencies, are necessary if we are to achieve a degree of success comparable to that reached in our earlier public health endeavors.

Please note new address: NOPHN, 2 Park Avenue, New York 16, N. Y.

International Health

SWEDEN

Sweden, a land where social policy is highly developed and official responsibility for health services marked, is moving to place the best in medical care within the reach of every citizen without special expense.

One major step has been taken, reports Ann Margret Lundgren of the Swedish Red Cross in the July-September *International Health Bulletin* of the League of Swedish Red Cross Societies. A program of compulsory health insurance and free hospital treatment for every citizen goes into operation next July. There is also agreement on the value of health centers in which the indissolubly related preventive and curative program in maternal and infant care, examination of school children, mass radiography, et cetera, is carried on. These services, which now reach a large proportion of the public, will be expanded.

Another proposal calls for a "health book" for every citizen. Each doctor consulted would enter results of his examinations and comments in the books.

Health insurance

The population, 60 percent of whom are now insured under private plans, will be completely covered under the new compulsory program. The benefits provided under the system, to which everyone except children and housewives who do not work must contribute, include allowances for medical expenses and for travel related to illness, on the basis of a fixed rate. That medical expenses may be greatly in excess of the fixed rate of indemnity is recognized and plans are being considered to remedy this flaw.

The patient selects his own doctor under the system. He is given free hospitalization, and, when hospitalized, receives a family allowance. Pharmacists make up needed prescriptions at half or no cost, receiving state refunds.

The government is exploring ways to increase its health personnel. Medical faculties of universities are being expanded. The age limit for enrollment in nursing school has been reduced from twenty-one to nineteen, and it is planned to shorten the period of professional training by six months. Changes in the preparation of the midwife are also in the offing. Since a high percentage of confinements now take place in nursing homes, the midwife's duties have shifted from attendance at confinements to preventive hygiene for mothers. Accordingly there are plans to transform her training into a combined preparation in nursing and midwifery.

WHO—UNICEF

A bright aspect of our international picture is the constructive work being done for children by UN's World Health Organization and the International Children's Emergency Fund. Their task is enormous. In large areas of the world child care services are virtually unknown. The infant mortality rate sometimes reaches 400 per thousand.

The policy of both agencies, aside from certain emergency aid, is to help nations set up their own programs for children, to show how rather than to do. To this end, WHO has set up advisory services in five of its six regional areas. From these centers public health nurses and advisers in maternal and child health and in malaria, tuberculosis, and venereal disease control fan out on projects for the governments in their areas. Some of these are joint undertakings in which WHO supplies the skilled staff and UNICEF supplies and equipment.

WHO's training program is an important part of its design to stimulate governments to build their own programs. During the past

two years sixty-eight fellowships were granted to health officers, doctors, and nurses from nineteen countries for training in modern technics of child care. WHO has aided governments to establish group training programs, encouraged reforms in professional education, and furthered the exchange of scientific information.

Epidemic control

In partnership the two agencies are bringing under control several epidemic diseases which threaten children. With the help of the Scandinavian Red Cross Societies they have given millions of children protection against tuberculosis through the BCG immunization campaign. Malaria has been successfully fought in southeast Asia and in the Eastern Mediterranean. Large numbers of young children in Haiti, Indonesia, and Thailand will be free of syphilis and yaws through their efforts.

Requests for aid from national governments run a wide gamut. WHO has helped the Philippine Republic to set up a child guidance program, Finland to discover the cause for an increase in infant mortality, Chile to deal with poliomyelitis. For some projects WHO and UNICEF pool their resources. A case in point is the child care program now under way in India.

India

The progressive Indian Government is striving to bring modern skills to a submerged and poverty-stricken population. Skilled child care personnel are desperately needed.

As a beginning answer, WHO has worked out with the Indian authorities a plan for a training program in strategic parts of the country. Pediatrics training centers will be set up in Madras, Patna, and Bombay while in the Delhi area rural and urban training fields for nurses and midwives will be developed.

In Calcutta a regional center is to be opened to train public health nurses and doctors engaged in the field of maternal and child health. It will be organized within the framework of the All-India Institute of Health and Public Hygiene, a voluntary organization which has itself developed a pioneering public health program. Both Indian and non-Indian students will receive free training at the center and take part in its demonstration field work.

See "The Problems and Needs of Maternal and Child Health as viewed by the World Health Organization" by Dr. Martha M. Eliot in the July-September 1950 *International Health Bulletin* of the League of Red Cross Societies, and the June 1950 *UNICEF in Asia* published by UNICEF.

UN's POPULATION COMMISSION

Will the economic assistance which UN is planning to give to underdeveloped areas of the world merely stimulate population growth in areas already overpopulated? Will the hoped for gains in more food and other necessities be dissipated in maintaining more people at the same low standard of living?

These and other questions concerned UN's Population Commission at its fifth session last May 22 to June 2, reports Philip M. Hauser, United States representative in the commission, in a release from the United States Mission to the UN.

Pointing out that the life-saving advances of medical science have created grave problems of overcrowding in some densely populated areas, the commission stressed the need to base future economic planning for backward regions on demographic studies. Such studies, which would include analyses of birth and death rates, migrations, et cetera, would make it possible for technological advances in these areas to keep ahead of population.

The commission applauded plans for a field study in India to determine the effects of recent vast technological changes on population groups in different parts of the nation. The survey will make on-the-spot studies of changes in population produced by major hydroelectric projects, irrigation works, new industries, and rapidly growing cities. This initial survey should go further, in the opinion of the commission, to include detailed inquiries on fertility and on the social characteristics of households. Its staff should include experts in such fields as economics and social anthropology.

New Books
And Other Publications

THE ENVELOPE

James S. Plant. New York, The Commonwealth Fund, 1950. 299 p. $3.00.

This book was published after Dr. Plant's death and is an extension of the meaning incorporated in his earlier book, *Personality and the Cultural Pattern*. The emphasis in his present book is slanted refreshingly in the direction of the social sciences. He states that his chief qualm was due to the false picture of simplicity in its presentation. This is hardly true, at least for this reviewer. It is a challenging treatise for professional workers in the children's field, regardless of school. Here school teachers, nurses, social workers, psychologists, and psychiatrists have a common meeting ground in a thoughtful attempt to understand the child in his world, not to treat him. Dr. Plant believes we must go beyond the easy sweeping stage of "certain biological needs" or "certain basic needs." The twenty-one fluctuating problems that the book deals with—both at the level of intake and outgo—raise many questions and settle none. The envelope is a sort of psychoosmotic membrane, so to speak—an interpreting aid to the child as to how much he can afford to take in and let out.

Dr. Plant—an admirable combination of the sensitive clinician and the scholar—has used a literary style in this book that is altogether pleasing and at times most colorful and vivid. This is not a book on psychopathology. He is not concerned with holistic concepts of mind-body tie-up or the unconscious as an entity, but considers everything from the point of view of the child—the one who must do the synthesizing. In short, he seems to be doing his own thinking throughout, and yet there is a generous documentation—especially along the social science lines—for use in postgraduate courses. By putting more of the individual into sociology, he has rendered a distinct service to all disciplines dealing with children.

He modestly ends on a note of high clinical importance. "The reader is not to feel that the child is at a certain point 'because he has had these experiences' but rather that the child is behaving at this point 'as if he had been having these experiences.' Thus the whole thing remains as merely an illustration of a way of attacking the problem of behavior."

The reviewer wishes to take this opportunity of congratulating The Commonwealth Fund on another notable publication.

—Spafford Ackerly, M.D., *Director of Louisville, Ky., Mental Hygiene Clinic*

A COMPARISON OF DIAGNOSTIC AND FUNCTIONAL CASEWORK CONCEPTS

Report of a committee to study basic concepts in casework practice. Cora Kasius, Editor. New York, Family Service Association of America, 192 Lexington Avenue. 1950. 169 p. $2.

This report of a committee appointed in June 1947 by the Family Service Association of America to study the technical differences in practice between the two orientations in the casework field has been long and eagerly awaited, not only by practitioners in this field but by many others in contact with the field who have been intrigued and baffled by a difference between two schools of thought and method which they sensed to be fundamental at the same time that it remained vague and elusive. When this difference was first recognized it was identified under the name of two psychoanalysts, Freud and Rank, whose theories of personality structure and of the dynamics of growth and change differed radically. As casework practice has gained greater confidence in its own unique opportunity and competence in helping people in need, the two schools of practice have

found designations" which more accurately characterize and differentiate their orientations, namely, diagnostic and functional.

When this committee was appointed, consisting of six representatives of each group, it was surely the hope of many in the field that out of the close association of these practitioners in studying and comparing their own case records there might come a discovery of a new unity more basic than apparent existing differences. It is a great tribute to the committee and particularly to its chairman, Eleanor Sheldon, of the functional group, and Patricia Sachs, chairman of the diagnostic group, that they never yielded to this hope of easy reconciliation. In every line of the report one sees the refusal to accept the "common descriptions of practice which at first glance seemed to be similar" in favor of the painstaking pursuit of deeper inherent meanings from which stem inevitable differences in method, technic, and practice.

The first section of the report gives a masterly comparison of basic concepts under the following headings: differences in concepts of personality structure, differences in method, and differences in concepts of responsibility. Each group also presents a more detailed statement of its basic concepts. Two case records from each group, given in detail with discussion by the writer, illustrate fully and convincingly the differences that have been stated. All four cases have inherent interest for any reader as illustrations of the kind of help that highly skilled caseworkers are able to offer. A careful reading of this report and a study of these records should enable the reader to make a real choice of the kind of help he would want for himself, for his family, or for his friend; or of the kind of agency he would choose to be associated with as a worker. A report which can do this much makes a contribution to the profession of social casework and to all who have any connection with it.

—Virginia P. Robinson, *Department of Social Casework, University of Pennsylvania School of Social Work*

GERIATRICS

Community Action for the Aging. Pamphlet published by the New York State Association of Councils of Social Agencies, 105 East 22 Street, New York 10. 1950. 15 p. 20c. Sets forth definite organizational and procedural steps to help the community combat "the enemies of the aging: economic insecurity, loneliness, and a feeling of uselessness."

Education for a Long and Useful Life. Homer Kempfer. Bulletin 6, 1950, Office of Education, Federal Security Agency, Washington 25, D. C. 52 p. 20c. Stresses the importance of the role of the public school in providing suitable learning opportunities for the older age group. Indicates beginning programs to be worked out by the schools and other educational agencies. The list of selected references is well chosen.

NURSING EDUCATION

The Future of Nursing Education. New York, Teachers College Bureau of Publications. 1950. 72 p. $1. Comments and greetings from outstanding leaders in various fields on the occasion of the fiftieth anniversary celebration of nursing education in Teachers College, Columbia University.

COMMUNITY ORGANIZATION

Directory of Community Health Planning Councils. National Health Council, 1790 Broadway, New York 19. 1950. 98 p. $1.

CHILD WELFARE

Priorities in Health Services for Children of School Age. Children's Bureau, Washington, D. C. 1950. 24 p. Single copies free, moderate charge for quantity orders.

GENERAL

Philadelphia Public Health Survey, 1949. Health and Welfare Council, Philadelphia 7. 1950. 241 p. $2.

The Rockefeller Foundation International Health Division Annual Report, 1949. 229 p. Available without charge from the Rockefeller Foundation, 49 West 49 Street, New York City.

Health Services in State Institutions of Higher Learning in Mississippi. Report of a survey. F. O. Robertson, Survey Director. American Council on Education, 744 Jackson Place, N.W., Washington 6, D.C. 1950. 67 p. $1.

(Continued on page A16)

FROM NOPHN HEADQUARTERS

MORE FIELD SERVICE AVAILABLE

When the Metropolitan Life Insurance Company announced that its own nursing services and its contracts with community agencies for nursing services would be terminated at the beginning of 1953, it also reported it would do everything possible to help agencies investigate new sources of income. As a very practical follow-up of this promise the MLI has loaned to the NOPHN three members of the Nursing Bureau to visit local agencies and help with analyses of services.

The field staff—the regular NOPHN consultants as well as the nurses on loan from the MLI—will be available during 1951, in so far as it is possible to cover requests for visits, wherever their assistance can strengthen existing public health nursing services or guide communities in setting up needed programs.

The NOPHN is planning to conduct four regional meetings during the early spring. Part of each conference will be devoted to a discussion of questions relating to the termination of the MLI service. As soon as the dates and places of the meetings are decided upon, announcements will be made.

Helen Snow, area supervisor, Marjorie L. Adams and Judith E. Wallin, territorial supervisors, are the nurses released by the MLI for the field service. In addition, the MLI has lent Helen Connors, a territorial supervisor, to be secretary to the ANA-NOPHN Committee on Nursing in Medical Care Plans. Miss Connors will visit and counsel groups interested in promoting the inclusion of nursing in medical plans and will, in general, implement the suggestions and recommendations of the "Guide," recently prepared by the committee.

CONFERENCE ON GRADUATE EDUCATION

The NOPHN will conduct a conference on graduate education in public health nursing

Helen Connors

Judith E. Wallin

All pictures Pach Bros.

Marjorie L. Adams

in New York April 30 to May 4, 1951. The purposes of the conference, sponsored by the Education Committee, are: to agree upon a statement of underlying philosophy for graduate education in public health nursing; to relate the objectives of graduate education in public health nursing to the general purposes of advanced nursing education; to review the criteria formerly established by the NOPHN Committee on Graduate Education in Public Health Nursing; to determine the conditions, faculty, and resources essential for maintaining satisfactory education for public health nurses on a graduate level; and such other purposes as the conference participants consider desirable.

Margaret S. Taylor, director, Course in Public Health Nursing, University of Minnesota School of Public Health, and chairman of the NOPHN Education Committee for the current biennium, will be the conference director. Members of the Education Committee and representatives from schools of public health, schools of nursing, and other national organizations will be invited to attend the conference. There will also be resource people from special fields.

UNITED DEFENSE FUND

The United Defense Fund, Inc., was launched on November 28, 1950, in New York City. A federation of national agencies and local community interests for the joint financing of national defense services in the field of health and welfare, the fund will offer to local communities a "single-package" appeal for support of national defense health and welfare services for both civilians and the armed forces.

The United Defense Fund was organized to meet the frequently expressed desire of local community chests that appeals to them from national agencies, especially in time of special need, be properly screened, budgeted, and united in their financing—just as is the community chest itself. Other reasons for the unification of these national agency services are (1) a desire not to increase the number of appeals now being made to the American public (2) a wish to join forces in carrying out needed services economically, efficiently, and effectively.

During the fall of 1950 a Planning and Advisory Committee on National Emergency Services was jointly appointed by Community Chests and Councils of America and the National Social Welfare Assembly to consider what services were needed and how they should be organized and financed. On the basis of recommendations of this committee, the United Defense Fund was set up.

Services to receive support from the fund fall into two groups at present. The first group is concerned with services to the armed forces and will be conducted by: the American Social Hygiene Association, Associated Services for the Armed Forces (which includes the Jewish Welfare Board, National Catholic Community Services, and YMCA), the National Recreation Association, National Travelers' Aid Association, and YWCA. The second group will provide services to communities congested by the national defense effort. These services will be conducted by: the Child Welfare League of America, National Organization for Public Health Nursing, National Federation of Settlements and Neighborhood Centers, National Urban League, National Catholic Community Service, National Recreation Association, and YWCA.

The United Defense Fund, Inc., will raise funds through the united campaign approach wherever possible and will seek support from the nation's community chests on a share-and-share-alike basis. Community quotas will be based on the recommendations of the National Quota Committee. The national campaign goal for services to be given in 1951 is $7,399,329. Community chests throughout the country will be asked to provide $6,058,101 of this goal with the remaining $1,341,228 to be secured from New York City and other non-chest sources.

STAFF NEWS

The New Year is a time for making new friends and also for renewing old friendships. We plan during the next few months to publish short informal sketches or accounts of the NOPHN staff. In this issue we reintroduce to you Anna Fillmore and Louise

Suchomel and present our newest staff member, Bessie Littman.

When Anna Fillmore accepted the position of general director of the NOPHN it was her desire to keep enough time free from administrative responsibilities and committee activities to go out into the field and meet public health nurses in their own communities. Few administrators have ever had heavier headquarters assignments than Miss Fillmore, but she has stuck to her resolve and has made several circuit trips around the country. Just recently she visited Kentucky, upstate New York, New Jersey, Baltimore, Maryland, and Augusta, Georgia, and she is looking forward to meeting hundreds of NOPHN members and friends in the spring.

As general director of the NOPHN Miss Fillmore is responsible for overall coordination of work at headquarters. She is secretary to the NOPHN Board of Directors and Executive Committee, Finance Committee, Advisory Council, and Committee on Structural Reorganization. She is a member of the Joint Board of Directors and its Steering Committee, the Joint Committee on the Unification of Accrediting Activities, the National Committee for the Improvement of Nursing Services, the Joint Committee on Nursing in National Security, the NOPHN-NLNE Councils on Tuberculosis Nursing and Orthopedic Nursing, and the Board and Executive Committee of the National Health Council, as well as being a member of related committees of other national organizations.

With the chief executives of the ANA and NLNE, Miss Fillmore takes her turn as head administrator for certain aspects of the work of joint projects of the six national nursing organizations as assigned by the Joint Board. During 1949 she carried this responsibility for the Joint Board and its Steering Committee. According to plans for 1951 it will be for the Coordinating Committee on Structure.

All this sounds like a fulltime job—and then some. But never fear, you have a good chance of meeting Miss Fillmore during 1951 at one of the NOPHN regional meetings, or, possibly, the Council of Branches, or a state meeting.

RESIGNATION

Jane R. Sloan, consultant with the Joint Orthopedic Nursing Advisory Service since June 1950, has resigned from the NOPHN staff to return to active duty with the Army Nurse Corps.

NEW MENTAL HEALTH CONSULTANT

Bessie Littman joined the staff in January as mental health consultant on the joint NLNE-NOPHN psychiatric and mental health project established under a training grant from the National Institute of Mental Health, Federal Security Agency. Mrs. Littman has

Pach Bros.
Anna Fillmore

Bessie Littman

Pach Bros.
Louise M. Suchomel

spent the last ten years in California but one can still detect her native Virginia in her soft speech. She is a graduate of Mt. Sinai Hospital School of Nursing in New York and has taken her public health nursing study and preparation in mental health at Teachers College, Columbia University. She holds B.S. and M.A. degrees.

Before going to California Mrs. Littman was on the staff of the Henry Street Visiting Nurse Service (now Visiting Nurse Service of New York). She spent one year with the Los Angeles VNA and then became director of nurses, San Luis Obispo County Health Department. Following this Mrs. Littman was appointed nurse consultant for mental health, California State Department of Public Health.

NOPHN has been looking forward to having a nurse consultant in mental health on the staff and is happy to welcome Bessie Littman.

POLIO OUTBREAK IN ALASKA

All the JONAS staff keep emergency bags packed ready to answer polio epidemic calls. Nevertheless, a request to leave for Alaska on twenty-four hours' notice was a new and exciting experience. Most of us think of Alaska as the frozen North and as America's last frontier. Travel agencies list mid-July to early September as the best time for visiting Alaska and suggest that the trip be made by boat and by the Alaskan Highway. Due to the urgency of the situation my entire trip in October was made by air, in planes ranging from stratocruisers to flying boats. In the short time available to me I tried to find out about the temperature in Alaska at the time and the type of clothing I would require. I followed advice and carried clothing —bulky woolens—which I never needed. Instead of the frozen North anticipated, the weather was "unusual." Temperatures averaged forty degrees above zero and during the first eight days there was no snow. When I got to Fairbanks, the farthest point north I visited, the temperature dropped to ten degrees above zero and there were five inches of snow to give me a taste of what Alaska weather might be.

Polio is not a frequent invader of areas such as Alaska and the community facilities and personnel are not adequate if the disease spreads to large numbers. Thus far only two natives have been among those stricken with polio. This is extremely fortunate as the Indians and Eskimos have had no opportunity to build up an immunity to polio and if many became ill a high fatality rate could be anticipated. Most of the natives live in small outlying communities where hospital facilities, and medical and nursing care are not readily available.

At the time of my visit six communities had reported cases of polio. The largest number were in Anchorage, Fairbanks, and Ketchikan. About 50 percent of the patients in Anchorage and Fairbanks were military personnel and their dependents, so that the responsibility for their care was shared by military and civilian professional personnel and hospitals. When polio is found in the proportion of one case to 10,000 population it is considered a high incidence and of epidemic height. Although the total number stricken in Alaska was not large, many of the localities had an incidence of one case to 900 population, which certainly seemed grave. The total capacity of the civilian hospitals in these communities averaged sixty-five to eighty-five beds. Admitting only four or six acutely ill polio patients places great burdens on the already shortstaffed hospitals. There were available a few physicians and a few nurses experienced in the care of poliomyelitis patients who were able to meet the immediate needs, but they could not cope with the care of an increasing number of patients. Additional nurses were recruited locally to care for patients with respiratory involvement.

Territorial planning presents many problems not found in planning here in the states. Alaska is a vast area: distances between the cities are great, hospital facilities are not available in all communities, and the chief means of transportation is air service. Neither the American Red Cross nor the NFIP has local chapters in Alaska. It was possible, nevertheless, to meet with representatives of the national groups and with representatives of the local graduate nurse associations to make plans.

The health authorities believed that if polio occurred in areas outside of the chief cities the patients would have to be brought in for care. The Tenth Rescue Squads at Fort Richardson and Ladd Air Base were prepared to transport essential equipment if necessary and to evacuate patients when hospital facilities were not available. Rosters of nurses and physical therapists were set up by the Alaska Health Department. I had been brought in to review the nursing needs and to participate in preparing local nurses for the care of the polio patients. I arranged for institutes to assist these nurses in meeting the constantly increasing demand. I gave the institutes at Anchorage and Fairbanks, and Helen Anderson, orthopedic nursing instructor from the University of Washington, who came up to assist me, gave the institutes at Juneau and Ketchikan. Public health nurses in the Alaskan services were very much aware of their responsibility in casefinding and assisted in securing medical care and follow-up of the discharged patients. They too are few in number in Alaska and are responsible for many health programs. Before I left we had conferences to plan for the longterm care that many of the polio patients would need.

Nursing in Alaska is truly pioneering and I regret that time did not permit me to learn more about the boat, railroad, and highway units. I look forward to a return trip under happier circumstances to enjoy more fully the beautiful mountains, glaciers, and lakes.

LOUISE M. SUCHOMEL JONAS

MORE ON THE NEW COST ANALYSES

The U. S. Public Health Service has approved the NOPHN's application for a research grant which will permit further study in the new method of cost analyses. (See "A Report on the Study of Costs in Public Health Nursing" published by NOPHN; price, 75 cents a copy.) The new analyses will include among other items study of student costs, length of period for the time study, and method of charging the time of consultants and the isolation of expenses chargeable to public health nursing.

ABOUT PEOPLE YOU KNOW

Governor Warren of California has appointed *Wilma York* to the Advisory Committee to the State Disaster Council on the Medical and Public Health Aspects of Civilian Defense. Miss York is director of nursing, Marin County Health Department, and formerly was territorial supervisor, MLI. . . . *Margaret M. Sullivan* has accepted the position of education director, Public Health Nursing Division, Worcester Department of Public Health (Mass.). . . . *Gertrude E. Hodgman,* who has served for many years in the fields of public health nursing and school of nursing administration in this and other countries, has been appointed director of the new Russell Sage College nursing program. . . . After twenty-five years of service, *Clara Pasche,* public health nurse in Blue Earth County, Minnesota, has retired. Miss Pasche was presented with a gift by the local Public Health Association and was honored editorially by the *Blue Earth County Enterprise.* . . .The Board of Directors of the VNA of York and York County, Pennsylvania, gave a tea in honor of *Nellie R. Price* upon her retirement after thirty-two years with the agency. For some time Miss Price has been assigned to school health service and she will be especially missed by the children she worked with. . . . Maryland State Department of Health announces the appointment of *Julia Freund* as public health nursing consultant in mental hygiene, Division of Public Health Nursing. Miss Freund is a graduate of the University of Washington and the Yale School of Nursing and holds professional diplomas in supervision in public health nursing and as a nurse specialist in mental hygiene from Teachers College, Columbia University. . . . *Miriam Whitaker* has also joined the Maryland State Department of Health as supervisor. She graduated from Cornell University-New York Hospital School of Nursing and has the degree of M.P.H. from Johns Hopkins School of Hygiene and Public Health where she had special study in mental hygiene. . . . *Mary Donnelly* has accepted the position of public health nurse coordinator in the basic program, School of Nursing, Boston University.

FIRST FOR '51!

One hundred percent staff membership in the NOPHN for 1951 had been reported by three public health nursing agencies, placing them at the top of our new list of 100% agencies, as we went to press. A special round of applause for these early birds! And be sure to let us know when *your* agency reaches the 100% goal.

MAINE
South Franklin County Tuberculosis and Health Association

PENNSYLVANIA
Visiting Nurse Association of Reading and Berks County

TENNESSEE
Memphis Metropolitan Life Insurance Nursing Service

SUPERVISION OF THE TUBERCULOUS

Jean South, NOPHN consultant, Joint Tuberculosis Nursing Advisory Service, has been appointed to the APHA Subcommittee on Administrative Problems in the Supervision of Tuberculosis Patients and Their Contacts. Dr. E. X. Mikol is chairman; the other members of the subcommittee are: Dr. O. L. Bettag, Mrs. Margaret Dolan, Zella Bryant, Dr. J. H. Fountain, Karen Munch, Dr. D. Reisner, and Dr. C. M. Sharp.

NOPHN FIELD SCHEDULE—DECEMBER

Marjorie L. Adams	Union City, N. J.
	Albany, N. Y.
Mary Elizabeth Bauhan	Newark, N. J.
Hedwig Cohen	Washington, D. C.
Ruth Fisher	Jefferson City, Mo.
Anne Prochazka	Washington, D. C.
Jean South	Atlanta, Ga.
Judith E. Wallin	Hammond, Ind.
	Moline, Ill.
	East Moline, Ill.
	Little Rock, Ark.
	Minneapolis, Minn.
	Winona, Minn.

NEW ADDRESS

On December 28 NOPHN, together with the ANA, NLNE, and AJN, moved from "1790" to 2 Park Avenue, New York 16, New York. We hope to be settled in a short time and that members and other friends will find their way to our new headquarters. If you cannot drop in, and if we can serve you, write or telephone. Our new number is ORegon 9-2040.

Where Are They Now?

(Continued from page 331)

Kiser, Betty J., 3761 Paseo Blvd., Kansas City
Swink, Edna M., 1613 Washington Blvd., Kansas City

NEBRASKA
Ellingwood, Marion E., 1036 S. 30 Avenue, Omaha
Heise, Charlotte M., 1021 Claremont, Lincoln
Roesky, Ardath, 3340 Taylor Street, Omaha

NEW JERSEY
Collins, Mrs. Dorothy R., 37 Gosselin Avenue, Ft. Monmouth

NEW YORK
Brady, Vera E., 320 W. 11 Street, New York 14
Holm, Alice E., St. Giles Hospital, 1346 President Street, Brooklyn
Littlefield, Mrs. Jane K., 88 Willett Street, Albany
Merriweather, Thyra, 1123 Intervale Avenue, Bronx 59
Nagano, Mrs. Dorothy, 500 Riverside Drive, New York
Powder, Frances, Brushton
Tajitsu, Yoneko, 507 W. 104 Street, New York

OHIO
Steadman, Patricia E., 2102 Cornell Road, Cleveland

PENNSYLVANIA
Sinton, Delphine D., 2242 S. 17 Street, Philadelphia 45

TENNESSEE
Malpas, Sarah A., Vanderbilt University School of Nursing, Nashville 4
Scheer, Mrs. Marian B., 1313 16th Avenue, S., Nashville 4

TEXAS
Sister M. Ancilla Castillo, Santa Rosa Hospital, San Antonio 7

VIRGINIA
Gorman, Mrs. Mary K., 311-A S. Sheppard Street, Richmond 20

NEWS AND VIEWS

THIRD MENTAL HEALTH ASSEMBLY

Psychiatrists, psychologists, sociologists, educators, social workers, and nurses from twenty-five nations attended the third annual meeting of the World Federation for Mental Health in Paris in September. Four subjects were highlighted. These were: mental health in education; occupational and industrial mental health; the mental health of transplanted and homeless persons; and leadership and authority in local communities. At the plenary sessions, papers on these subjects were read. Later eleven groups, each of about fourteen persons, representative of all the interested professions, discussed the same topics.

Professor Andre Rey, discussing teachers' training, commented on how little on the subject of mental health was included in most curriculums. He stressed the need for assistance to the parents of adolescents who so often try to shake off the shackles imposed on them in childhood and perplex their parents by their behavior.

The manner in which the results of scientific research were made public was criticized by Dr. R. F. Tredgold. He said findings in the field of the social sciences were often couched in terminology which antagonized the industrialist, who also found the reports difficult to understand. In spite of such unfortunate antagonisms, industrialists in general find planned programs for improving the mental health of the worker worthy of support.

The subject of the mental health of displaced persons was discussed by Professor John Cohen of Israel who applied his comments not only to exiled people in remote parts of the world but also to individuals in our settled communities, such as the child in a hospital, the old person in a home for the aged, the man in the army. Displacement has always existed; what is new is the attempt to reduce the hardship and dovetail the life of the newcomer into the receiving community.

Statesmanship was described by Professor Gregory Zilboorg as the art of established leadership. Our social structure compels the statesman to wear a kind of psychological armor. The greater the power of the leader in our society the more sheltered he is from the impact of reality, but the moralist and the psychologist should seek to enhance the sense of reality and responsibility and limit the sense of power of those in authority.

Many interesting recommendations were brought into the final meeting by the discussion groups. Fields for objective studies were listed. One suggestion was that experiments should be undertaken to ascertain desirable and undesirable qualities in leadership in various spheres and at various levels. Doubtless we shall hear more about the proposals and recommendations in the year to come.

SURVIVAL UNDER ATOMIC ATTACK

Basic precautions which may save your life if an atom bomb raid should come are set forth in "Survival under Atomic Attack," prepared for the public by the National Security Resources Board. Written clearly and simply, the pamphlet emphasizes the positive things that can be done, allaying blind fears.

It tells frankly what to expect within various distances from an atomic explosion. Most of the deaths and damage in atomic explosions are due to blast and heat rather than radioactivity.

If you are caught in the open, drop down beside a substantial building or in a ditch or gutter, burying your face in your arms. If you have time to reach it, the basement of a

substantial house is a good refuge against the bomb's blast, heat, and explosive radiation. Lie flat along the outer wall of the basement or near the base of some heavy supporting column, or even better under a cellar work bench or heavy table. If you cannot reach a basement, any culvert, deep gully, or even a high bank will give some protection.

If there is time after an alert sounds, close all doors and windows in the house to keep out fire sparks and radioactive dusts. Close the doors of furnaces and stoves. Always keep on hand a good flashlight, first aid equipment, a supply of canned goods, and a radio which may be your only source of emergency instructions.

After an atomic burst in the air it is safe to leave your shelter in a few minutes to help other people. However, if civil defense authorities report that the explosion has been on the ground, underground, or in the water, stay in your shelter for at least an hour. In these types of explosions, there may be dangerous lingering radiation.

After an air burst, food in the house will be safe to use. In the case of a ground or underwater burst, however, use only canned or bottled foods, scrubbing the outsides of the containers thoroughly. Draw off a little water from the pipes for drinking but do not continue to take water from the tap until you are told it is safe.

The pamphlet, which contains many other pointers for surviving an atomic blast and helping your community to do so, may be secured for 10 cents from the U. S. Government Printing Office, Washington 25, D. C. *Get a copy.*

BRUCELLOSIS

The importance of brucellosis as a world public health problem is attested to by two important conferences on this subject held in Washington in November. The Third Inter-American Congress on Brucellosis, sponsored by the Inter-American Committee on Brucellosis, the National Research Council, and the Pan American Sanitary Bureau, was followed by the First International Expert Panel on Brucellosis, organized by two UN agencies, the World Health Organization and the Food and Agriculture Organization.

Brucellosis affects cattle, goats, and swine and is transferrable to humans in whom the condition, known as undulant fever, causes a greatly reduced ability to work as well as prolonged physical suffering. It is estimated that the economic losses from brucellosis infection in France exceed $100,000,000 and that the losses in the United States probably are as great. This is figured on the basis of work days lost, cost of caring for the sick, and decreases in milk and meat production. In Norway where brucellosis of cattle has been eliminated, the cost of the eradication program was estimated to be less than the loss caused by the disease in any year.

Recent advances in the development of the antibiotics, especially aureomycin and terramycin, have given increased hope for the treatment of individuals with undulant fever.

The Illinois Health Messenger (November 15, 1950) describes a simple Ring Test for the discovery of brucellosis in cows. This test costs only about one tenth of the cost of the routine blood test.

SHOCK IN BURNS

The simple rules for using salt and soda water by mouth as first aid for serious shock from burns are outlined in a leaflet issued by the Public Health Service, Federal Security Agency.

In releasing the leaflet, titled "The A, B, C's of Salt and Soda for Shock in Burns," Surgeon General Leonard A. Scheele pointed out that "in the salt and soda solution, given by mouth, we have a practical and highly effective first aid against shock, the major killing factor in burns and many injuries."

The text emphasizes that any badly burned person needs the care of a doctor as soon as possible. He also needs first aid for shock immediately. He may be saved from shock—and even death—by giving him salt and soda in water to drink at the earliest possible moment.

The salt solution consists of 1 level teaspoon of common table salt and ½ teaspoon of baking soda (bicarbonate of soda) dissolved in 1 quart of cool water. A burned person should drink this and nothing else. As much

as 10 quarts in twenty-four hours may be necessary.

Single copies of the leaflet may be obtained from the Public Health Service, Federal Security Agency, Washington 25, D. C.

SAVE THE CHILDREN

Many deaths and injuries to children are caused by the speed with which their clothing burns after being ignited by party candles, matches, or bonfires. The National Board of Fire Underwriters suggests a simple and inexpensive flame-proofing solution which can be prepared in any home. Dissolve 9 ounces of *borax* and 4 ounces of *boric acid* in 1 gallon of water. Dip the dress in the solution. This solution is safe to use on any material that can be put in water but should be reapplied each time the garment is washed. It will flame-proof curtains and drapes also.

RURAL HEALTH COOPERATIVES

Rural groups in twenty-one states have formed cooperatives to help meet their health needs. How they tackled such obstacles as building membership and community support, financing construction, obtaining personnel, and meeting costs of operation, is discussed in a joint publication of the Public Health Service and the Farm Credit Administration, "Rural Health Cooperatives" (PHS Bulletin 308, FCA Bulletin 60).

The experience of forty-eight of the known 101 rural health cooperatives in the United States before mid-1949 is given in the ninety-three-page publication. Taken as a whole, their record shows the willingness of many rural people to devote a great deal of time, effort, and money to safeguarding family and community health.

Rural health cooperatives utilize local interest and effort, making health improvement the business of the people of the community. Through cooperatives, doctors and local people work together to promote greater understanding of good health, how it can be maintained, and what it can mean to families and communities.

While the supply lasts, single copies of "Rural Health Cooperatives" may be secured from the Division of Medical and Hospital Resources, Public Health Service, FSA, Washington 25, D. C.

SCHOOL NURSE SUPERVISORS

The New Jersey School Nurse Supervisors' Association was formed in Trenton in October. The following officers were elected: president, Mary B. Hulsizer, Newark; vice-president, Llouella L. Haage, Jersey City; secretary, Evelyn Joyner, Trenton; treasurer, Marie Meyers, Wayne Township. The association will hold its next meeting in Morristown in April 1951.

• A seminar in physical rehabilitation methods for nurses will be offered February 26 to March 9 at the New York University-Bellevue Medical Center Institute of Physical Medicine and Rehabilitation. The course is designed to give both theoretical and practical instruction in testing and self-care, elevation, and ambulation. Attention will be given to the total concept of rehabilitation and to the working relationships of the nurse and the many other individual members of the rehabilitation team. The tuition fee is $50. For further information write to Miss Edith Buchwald, Institute of Physical Medicine and Rehabilitation, 414 East 34 Street, New York 16.

• The National Association of Colored Graduate Nurses has completed plans for its final public gathering, a testimonial dinner honoring some of those who have helped to further democracy in nursing. Judge William Hastie, former governor of the Virgin Islands, will be the guest speaker. The Mary Mahoney Medal for distinguished service to nursing and the community will be awarded to Mrs. Eliza J. Pillars of Jackson, Mississippi.

The NACGN extends a cordial invitation to all its friends and well-wishers to attend the dinner at the Colonnades, Essex House, in New York on Friday, January 26, 1951, at seven-thirty. Tickets are $10 each. For reservations, call or write NACGN, 1790 Broadway, New York 19 (Circle 5-8000, extension 15).

OFFICIAL DIRECTORY OF PUBLIC HEALTH NURSING

A list of those holding executive positions in the Federal Government, in national organizations, and in states and territories; officers of state organizations for public health nursing, and executive secretaries of state nurses associations

Information as of December 1, 1950, unless otherwise stated.

National Organization for Public Health Nursing, Inc.
President, Emilie G. Sargent, Executive Director, Visiting Nurse Association of Detroit, 51 W. Warren Avenue, Detroit 1, Michigan
General Director, Anna Fillmore, 2 Park Avenue, New York 16, N. Y.

American Association of Industrial Nurses
President, Mrs. Mary Delehanty, Equitable Life Assurance Society, New York, N. Y.
Executive Secretary, Mrs. Gladys L. Dundore, Room 909, 654 Madison Avenue, New York 21, N. Y.

American Nurses Association
President, Mrs. Elizabeth K. Porter, Frances Payne Bolton School, Western Reserve University, 2063 Adelbert Road, Cleveland 6, Ohio
Executive Secretary, Ella G. Best, 2 Park Avenue, New York 16, N. Y.

Association of Collegiate Schools of Nursing
President, Elizabeth S. Bixler, Yale School of Nursing, 310 Cedar Street, New Haven, Connecticut

National Association of Colored Graduate Nurses
President, Mrs. Mabel K. Staupers, 1274 Fifth Avenue, New York 29, N. Y.
Executive Secretary, Mrs. Alma Vessells John, 2 Park Avenue, New York 16, N. Y.

National League of Nursing Education
President, Agnes Gelinas, 303 E. 20 Street, New York 3, N. Y.
Executive Director, Julia M. Miller, 2 Park Avenue, New York 16, N. Y.

Joint Board of Directors of the Six National Nursing Organizations, 2 Park Avenue, New York 16, N. Y.
Chairman, Pearl McIver

Joint Coordinating Committee on Structure, 2 Park Avenue, New York 16, N. Y.
Chairman, Pearl McIver

National Nursing Accrediting Service, 2 Park Avenue, New York 16, N. Y.
Director, Helen Nahm

National Committee for the Improvement of Nursing Services, 2 Park Avenue, New York 16, N. Y.
Director of Programs, Marion W. Sheahan

Committee on Careers in Nursing, 2 Park Avenue, New York 16, N. Y.
Director of Public Relations, Mrs. Muriel C. Henry

National Association for Practical Nurse Education, 654 Madison Avenue, New York 21, N. Y.
President, Ella M. Thompson
Executive Secretary, Hilda M. Torrup

National Security Resources Board, Health Resources Division, Washington 25, D.C.
Nursing Consultant, Ruth Freeman

American National Red Cross, Nursing Services, National Headquarters, Washington 13, D.C.

Administrator, Nursing Services, Ann K. Magnussen
Deputy Administrator, Nursing Services, Frances Crouch
Director, Home Nursing and Nurse's Aide Instruction, Olivia T. Peterson
Director, Nursing Projects, Eula B. Butzerin
Executive Assistant National Director, Nursing Services, Blood Program, Evelyn T. Stotz

Areas

Eastern Area, 615 N. St. Asaph Street, Alexandria, Va.—Jessie W. Herr, Director, Nursing Service
Southeastern Area, 230 Spring Street, Atlanta 3, Georgia—Jeanie L. Adkerson, Director, Nursing Service
Midwestern Area, 1709 Washington Avenue, St. Louis 3, Mo.—Lona L. Trott, Director, Nursing Service
Pacific Area, 1550 Sutter Street, San Francisco 1, California—Irene Thompson, Director, Nursing Service

Army Nurse Corps
Chief, Col. Mary G. Phillips, Nursing Division, Office of The Surgeon General, U. S. Army, Main Navy Building, Washington 25, D.C.

Navy Nurse Corps
Director, Captain Winnie Gibson, Potomac Annex, Navy Department, Washington 25, D.C.

Air Force Nurse Corps
Acting Chief, Lt. Col. Verena M. Zeller, Office of The Surgeon General, U. S. Air Force, Washington 25, D.C.

U. S. Civil Service Commission, Medical Division
Nursing Consultant, Ruth A. Heintzelman, 8th and F Streets, Washington 25, D.C.

U. S. Department of the Interior, Bureau of Indian Affairs
Chief Consultant in Nursing, Bureau of Indian Affairs, Washington 25, D.C. (Position Unfilled)
Consultant in Public Health Nursing, Bertha M. Tiber, Bureau of Indian Affairs, Washington 25, D.C.
Consultant in Hospital Nursing, Mary E. Gahagan, Bureau of Indian Affairs, Washington 25, D. C.
Area Consultant in Nursing, K. Frances Cleave, Bureau of Indian Affairs, 804 N. 29 Street, Billings, Montana
Area Consultant in Nursing, Jean Clair Casey, Bureau of Indian Affairs, Swan Island, Bldg. 34, Portland 18, Oregon
Area Consultant in Nursing, Imogene Yarbrough, Bureau of Indian Affairs, P. O. Box 1150, Aberdeen, South Dakota
Area Consultant in Public Health Nursing, Beulah Oldfield, Bureau of Indian Affairs, Federal Building,

Anadarko, Oklahoma
Area Consultant in Hospital Nursing, Martha E. Keaton, Bureau of Indian Affairs, Federal Building, Muskogee, Oklahoma
Area Consultant in Nursing, Priscilla Parker, Bureau of Indian Affairs, Juneau, Alaska
Area Consultant in Nursing, P. O. Box 7007, Bureau of Indian Affairs, Phoenix, Arizona (Position Unfilled)

U. S. Department of State
Mrs. Maxine T. Smith, Chief Nurse

Federal Security Agency

U. S. Children's Bureau, Federal Security Building, Washington 25, D.C.
Nursing Section
Chief, Ruth G. Taylor
Assistant Chief, Alice F. Brackett
Special Consultant in Nurse Midwifery and Maternity Nursing, Ruth Doran

International Cooperation Service
Caroline Russell

Regional Nursing Consultants and Districts
Lucille Woodville, Children's Bureau, FSA, Room 629, Ten Forsyth Street, Atlanta 3, Georgia—Tennessee, Mississippi, Alabama, Florida, South Carolina, Georgia
Gertrude M. Church, Children's Bureau, FSA, Room 200, 69 W. Washington Street, Chicago 2, Illinois—Michigan, Ohio, Kentucky, Minnesota, Wisconsin, Illinois, Indiana
Margaret A. Hockenberger, Children's Bureau, FSA, 201 Norman Building, Dallas 2, Texas—Louisiana, Arkansas, Texas, Oklahoma, New Mexico
Lucile A. Perozzi, Children's Bureau, FSA, 321 Equitable Building, 730 17 Street, Denver 2, Colorado—Montana, Idaho, Wyoming, Utah, Colorado
Jane Nicholson, Children's Bureau, FSA, Room 2200, 911 Walnut Street, Kansas City 6, Missouri—North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri
Agnes Fuller, Children's Bureau, FSA, Room 1200, 42 Broadway, New York 4, New York—Maine, Vermont, New Hampshire, Massachusetts, Connecticut, Rhode Island, New York, Pennsylvania, New Jersey, Delaware
Margaret Thomas, Children's Bureau, FSA, Room 443, Federal Office Building, Civic Center, San Francisco 2, California—Washington, Oregon, California, Nevada, Arizona, Alaska, Hawaii
Lalla M. Goggans, Children's Bureau, FSA, Room 2035, Federal Security Building, Washington 25, D.C.—Maryland, District of Columbia, Virginia, North Carolina, West Virginia, Puerto Rico, Virgin Islands

U. S. Public Health Service, Federal Security Building, 4th Street and Independence Avenue, S.W., Washington 25, D.C.
Chief Nurse Officer, Lucile Petry

Office of the Surgeon General
Division of International Health Relations, Chief Nurse, Virginia Arnold; Division of Commissioned Officers, Nurse Liaison Officer, L. Margaret McLaughlin

Bureau of Medical Services, Federal Security Building South, 4th and C Streets, S.W., Washington 25, D.C.
Division of Nursing Resources, Chief, Margaret G. Arnstein
Division of Hospitals, Nursing Section Chief, Elsie Berdan
Division of Medical and Hospital Resources, Nursing Section Chief, Louise O. Waagen

Bureau of State Services, Federal Security Building South, 4th and C Streets, S.W., Washington 25, D.C.
Division of Public Health Nursing, Chief, Pearl McIver
Division of Chronic Disease, Chief Nursing Consultant, Frances E. Taylor
Division of Industrial Hygiene, Chief Nursing Consultant, Winifred Devlin
Industrial Hygiene Field Station, Box 2537, Fort Douglas Station, Salt Lake City, Utah, F. Ruth Kahl
Division of State Grants, Chief Nursing Consultant, Marion Ferguson
Division of Tuberculosis, Chief Nursing Consultant, Zella Bryant
Division of Venereal Disease, Chief Nursing Consultant, Hazel Shortal
Communicable Disease Center, 605 Volunteer Building, Atlanta, Georgia, Chief Nursing Consultant, L. Dorothy Carroll

Regional Public Health Nursing Consultants
120 Boylston Street, Boston 16, Massachusetts, Lillian A. Gardiner
Room 1200, 42 Broadway, New York 4, New York, Helen Bean
Room 2418, Federal Security Bldg., Washington, D.C., Daphine D. Doster
1100 Chester Avenue, Cleveland 14, Ohio, Lorena Jane Murray
Room 200, 69 West Washington Street, Chicago 2, Illinois, Mrs. Mabelle J. Markee
John Silvey Building, 114 Marietta Street, Atlanta 3, Georgia, Mrs. Florence H. Callahan
2300 Fidelity Building, 911 Walnut Street, Kansas City 6, Missouri, Margaret Denham
201 Norman Building, Ross Street and Lamar Avenue, Dallas 2, Texas, Frances Buck
9 Equitable Bldg., 730 17 Street, Denver 2, Colorado, Lily C. Hagerman
441 Federal Office Building, San Francisco 2, California, Mrs. Vera P. Hansel

National Institutes of Health, Bethesda, Maryland
National Institute of Mental Health
Community Services Branch, Mental Health Nurse Consultant, Pearl Shalit
Hospital Inspection Section, Consultant in Psychiatric Nursing, Mary E. Corcoran
Training and Standards Branch, Consultant in Psychiatric Nursing Education, Esther Garrison
Training Specialist (Psychiatric Nursing), Evelyn Gombert

National Cancer Institute
Cancer Control Branch, Nursing Section Chief, Rosalie I. Peterson

U. S. Veterans Administration, Nursing Service, Central Office, Washington 25, D.C.
Director, Dorothy V. Wheeler
Deputy Director, Ruth Addams
Community Nursing Division
Chief, Iva Torrens
Assistant Chief, Alice C. Mooney

Pan American Sanitary Bureau, Regional Office of United Nations World Health Organization, 2001 Connecticut Avenue, N.W., Washington 8, D.C.
Mrs. Agnes W. Chagas, Chief, Nursing Section, Washington, D.C.
Elfleda L. Sprague, Public Health Nursing Consultant, Washington, D.C.
Franziska Glienke, Nursing Consultant, Guatemala City, Guatemala
Alice E. Barnes, Nursing Consultant, Lima, Peru
Mary X. Rogan, Nursing Consultant, San José, Costa Rica
Frances E. Fell, Nursing Consultant, Quito, Ecuador
Hilda Lozier, Nursing Section, *Boletín,* Washington, D.C.

ALABAMA

State Department of Public Health—Catherine Corley, Director, Division of Public Health Nursing, Bureau of County Health Work, Montgomery 4
State Nurses Association Executive Secretary—Mrs. Walter B. Smith, 334 Professional Center, Catoma and Church Streets, Montgomery

ALASKA

Department of Health—Dorothy K. Whitney, Director, Division of Nursing, Juneau

ARIZONA

State Department of Health—Miss Jefferson I. Brown, Director, Division of Public Health Nursing, Phoenix
State Nurses Association Executive Secretary—Dylis Salisbury, 538 N. 10 Street, Phoenix

ARKANSAS

State Organization for Public Health Nursing—President, Mrs. Marjorie Gamble, County Health Department, Newport. Secretary, Mrs. Helen Mahaffey, Garland County Health Department, Hot Springs
State Board of Health—Margaret S. Vaughn, Director, Division of Public Health Nursing, Bureau of Local Health Service, Little Rock
State Nurses Association Executive Secretary—Linnie Beauchamp, 816 Pyramid Building, Little Rock

CALIFORNIA

State Organization for Public Health Nursing—President, Mrs. Fannie T. Warncke, 282 Eighth Street, Oakland 7. Secretary, Robina Walters, American Red Cross, San Francisco.
State Department of Public Health—Rena Haig, Chief, Bureau of Public Health Nursing, Division of Preventive Medical Services, Room 751, 760 Market Street, San Francisco 2
State Nurses Association Executive Director—Shirley C. Titus, 185 Post Street, San Francisco 8

COLORADO

State Department of Public Health—Mrs. Vesta Bowden, Director, Public Health Nursing Section, Denver
State Nurses Association Executive Secretary—Elizabeth M. Rauch, 728 15 Street, Denver 2

CONNECTICUT

State Department of Health—Hazel V. Dudley, Director, Bureau of Public Health Nursing, Hartford
State Department of Education—Mrs. Helen T. Watson, Consultant Public Health and School Nursing, Hartford
State Nurses Association Executive Secretary—Mrs. Helen M. Cullen, Room 502, 252 Asylum Street, Hartford 3

DELAWARE

State Board of Health—Mary M. Klaes, Director, Division of Public Health Nursing, Dover
State Nurses Association Executive Secretary—Mrs. Eleanor P. Jester, 911 Delaware Avenue, Wilmington 9

DISTRICT OF COLUMBIA

District of Columbia Health Department—Mrs. Josephine Pitman Prescott, Director, Bureau of Public Health Nursing, Washington 1
District of Columbia Nurses Association Executive Secretary—Edith M. Beattie, 1790 M Street N.W., Washington 9

FLORIDA

State Board of Health—Ruth E. Mettinger, Director, Division of Public Health Nursing, Bureau of Local Health Service, Jacksonville 1
State Nurses Association Executive Secretary—Helen E. Shearston, 10 N.E. Third Avenue, Miami 32

GEORGIA

State Organization for Public Health Nursing—President, Mrs. Veronica Richeimer, City-County Health Department, Columbus. Secretary, Mary Copeland, City-County Health Department, Columbus
State Department of Public Health—Theodora Floyd, Director, Division of Public Health Nursing, Atlanta 7
State Nurses Association Executive Secretary—Mrs. Mildred B. Pryse, 800 Peachtree Street, N.E., Atlanta 5

HAWAII

Territory of Hawaii Department of Health—Laura A. Draper, Chief, Bureau of Public Health Nursing, Division of Local Health Services, Honolulu 1
Hawaii Nurses Association Secretary—Mrs. Mabelclair Norman, 510 S. Beretania Street, Honolulu 13

IDAHO

State Department of Public Health—Florence V. Whipple, Director, Division of Nursing, Boise
State Nurses Association Executive Secretary—Mabel Shade, 906½ Jefferson Street, Boise

ILLINOIS

State Department of Public Health—Maude B. Carson, Chief, Bureau of Nursing, Springfield
State Nurses Association Executive Secretary—June A. Ramsey, 8 S. Michigan Avenue, Chicago 3

INDIANA

State Board of Health—Ethel R. Jacobs, Director, Division of Public Health Nursing, Bureau of Local Health Administration, Indianapolis 7
State Nurses Association Acting Executive Secretary—E. Nancy Scramlin, 1125 Circle Tower, Indianapolis 4

IOWA

State Organization for Public Health Nursing—President, Mae R. Campbell, 406 Center, Des Moines. Secretary, Jeolla Antes, R.F.D. No. 1, Iowa City
State Department of Health—Mattie Brass, Director, Division of Public Health Nursing, Des Moines
State Nurses Association Executive Secretary—Jessie P. Norelius, 503 Shops Building, Des Moines 9

KANSAS

State Board of Health—Theresa Jenniges, Director, Public Health Nursing Services, Division of Local Health Administration, Topeka
State Nurses Association Executive Secretary—Irma Law, 824 Kansas Avenue, Topeka

KENTUCKY

State Organization for Public Health Nursing—President, Alice Clark, State Dept. of Health, Louisville. Secretary, Mrs. Martine Lowry, Grayson County Health Dept., Litchfield
State Department of Health—Margaret L. East, Director, Division of Public Health Nursing, Louisville 2
State Nurses Association Executive Secretary—Cynthia J. Neel, 604 S. 3 Street, Louisville 2

LOUISIANA

State Organization for Public Health Nursing—President, Marion Souza, Supervisor, Health Education, Board of Education, Capitol, Baton Rouge 4. Secretary, Mrs. Elizabeth Engeran, 829 Lafayette Street, Gretna
State Department of Education—Marion Souza, Supervisor, Health Education, Baton Rouge 4
State Department of Health—Lillian Jeffers, Director, Division of Public Health Nursing, New Orleans 7
State Nurses Association Executive Secretary—Christine Causey, 2005 Prytania Street, New Orleans 13

MAINE

State Department of Health and Welfare—Helen E. Dunn, Director, Division of Public Health Nursing, Bureau of Health, Augusta
State Nurses Association Executive Secretary—Mrs. Helen Townsend, 146 State Street, Augusta

MARYLAND

State Organization for Public Health Nursing—President, Alice Sundberg, Charles and 34 Streets, Baltimore 18. Secretary, Wilda Snyder, 3901 Garrison Blvd., Baltimore 15
State Department of Health—Helen L. Fisk, Chief, Division of Public Health Nursing, Baltimore 18
State Nurses Association Executive Secretary—M. Ruth Moubray, 1217 Cathedral Street, Baltimore 1

MASSACHUSETTS

State Organization for Public Health Nursing—President, Mrs. John J. Harrington, 110 Main Street, Waltham. Secretary, Mrs. Sidney B. Whittier, 11 Kennedy Road, Cambridge
State Department of Public Health—Ethel G. Brooks, Chief, Public Health Nursing Section, Boston
State Nurses Association Executive Secretary—Edith V. Peterson, 420 Boylston Street, Boston 16

MICHIGAN

State Organization for Public Health Nursing—President, Barbara Wilcox, Barry County Health Dept., Hastings. Secretary, Margaret Maxwell, Kalamazoo City County Health Dept., Kalamazoo
State Department of Health—Helene Buker, Chief, Public Health Nursing Section, Division of Local Health Administration, Lansing 4
State Nurses Association Executive Secretary—Jean Truckey, 470 Hollister Bldg., Lansing 8

MINNESOTA

State Organization for Public Health Nursing—President, Helen Law, Board of Education, Mound. Secretary, Eleanor J. Leckner, 4321 W. Broadway, Robbinsdale
State Department of Health—Ann S. Nyquist, Director, Division of Public Health Nursing, Minneapolis 14
State Nurses Association Executive Secretary—Ragna Gynild, 2395 University Avenue, St. Paul 4

MISSISSIPPI

State Board of Health—Louise Holmes, Director, Division of Public Health Nursing, Jackson 113
State Nurses Association Executive Secretary—Kate Lou Lord, 705 North Street, Jackson

MISSOURI

State Department of Public Health and Welfare—Helen E. Kinney, Director, Bureau of Nursing, Division of

Health, Jefferson City
State Nurses Association Executive Secretary—Marjorie Elmore, 712 E. High Street, Jefferson City

MONTANA

State Board of Health—Wava L. Dixon, Acting Director, Division of Public Health Nursing, Helena
State Nurses Association Executive Secretary—Muriel Lewis, 11-14 Lalonde Block, Helena

NEBRASKA

State Organization for Public Health Nursing—President, Alice Jensen, 935 R Street, Lincoln. Secretary, Mona Overton, 606 City Hall, Omaha
State Department of Health—Emily Brickley, Director, Division of Public Health Nursing, Lincoln
State Nurses Association Executive Secretary—Mrs. Catherine Gehrman, 338 Electric Building, Omaha 2

NEVADA

State Department of Health—Margaret J. Nichols, Acting Director, Division of Public Health Nursing, Reno
State Nurses Association Executive Secretary—Mrs. Della Fitzgerald, 1100 S. 17 Street, Las Vegas

NEW HAMPSHIRE

State Department of Health—Florence M. Clark, Director, Division of Public Health Nursing, Concord
State Board of Education—Vacancy
State Nurses Association Executive Secretary—Mrs. Mary T. Madden, Room 5, 63 N. Main Street, Concord

NEW JERSEY

State Organization for Public Health Nursing—President, Madelyn N. Hall, 703 Watchung Avenue, Plainfield. Corresponding Secretary, Mary Allen, 42 N. Maple Street, Woodbury
State Department of Health—Mrs. Gladys J. Wilson, Chief, Public Health Nursing Bureau, Division of Local Health Service, Trenton 7
State Department of Education—Lulu P. Dilworth, Assistant in Health Education, Trenton
State Nurses Association Executive Secretary—Wilkie Hughes, 17 Academy Street, Newark 2

NEW MEXICO

State Department of Public Health—Portia Irick, Director, Division of Public Health Nursing, Santa Fe
State Nurses Association Executive Secretary—Mrs. Mary Jane Carter, 3125 N. 12 Street, Albuquerque

NEW YORK

State Department of Health—Mary E. Parker, Director, Bureau of Public Health Nursing, Albany
State Education Department—Josephine McFarland, Associate Education Supervisor of School Nursing, State Education Building, Albany 1
State Nurses Association Executive Secretary—Katherine E. Rehder, 385 State Street, Albany 6

NORTH CAROLINA

State Board of Health—Amy L. Fisher, Chief, Public Health Nursing Section, Local Health Division, Raleigh
State Nurses Association Executive Secretary—Mrs. Marie B. Noell, 306 S. Dawson Street, Raleigh

NORTH DAKOTA

State Department of Health—Marjorie W. Spaulding, Director, Division of Public Health Nursing, Bismarck
State Nurses Association Executive Secretary—Gladys E. Wentland, 309½ Main Avenue, Bismarck

OHIO

State Department of Health—S. Gertrude Bush, Chief, Division of Nursing, Columbus 15
State Nurses Association General Secretary—Mrs. E. P. August, Huntingdon Bank Building, 17 S. High Street, Columbus 15

OKLAHOMA

State Department of Health—Josephine L. Daniel, Director, Division of Nursing, Oklahoma City
State Nurses Association Executive Secretary—Mrs. Nan Green, 304 Hightower Building, Oklahoma City

OREGON

State Organization for Public Health Nursing—President, Mrs. Catherine Webster, 2825 N.E. 35 Place, Portland 13. Secretary, Mrs. Doris Gerry, Multnomah County Health Department, Court House, Portland 4
State Board of Health—Jane D. Gavin, Acting Director, Public Health Nursing Section, Division of Preventive Medical Services, Portland 5
State Nurses Association Executive Secretary—Viola M. Vreeland, 220 S.W. Alder Street, Portland 4

PENNSYLVANIA

State Organization for Public Health Nursing—President, Mary Beam, Public Health Nursing Service, Lansdowne. Secretary, Margaret Keller, VNA, York
State Department of Health—Alice M. O'Halloran, Director, Bureau of Public Health Nursing, Harrisburg
State Department of Public Instruction—Mildred S. Coyle, School of Nursing Adviser, Harrisburg
State Nurses Association General Secretary—Mrs. Katharine E. F. Miller, 2515 N. Front Street, Harrisburg

PUERTO RICO

Puerto Rico Department of Health—Mrs. Paulina R. Davila, Chief, Bureau of Public Health Nursing, San Juan
Puerto Rico Nurses Association Secretary—Elisa Carpena, Box 1814, San Juan

RHODE ISLAND

State Organization for Public Health Nursing—President, Catherine Sullivan, Rhode Island State Health Department, State Office Building, Providence. Secretary, Mary Kennedy, City Dept. of Health, City Hall, Providence
State Department of Health—Mrs. Catherine O. Tracy, Director, Bureau of Public Health Nursing, Providence
State Nurses Association Executive Secretary—Helen O. Potter, 42 Weybosset Street, Providence

SOUTH CAROLINA

State Organization for Public Health Nursing—Mrs. Minnie H. Blease, Saluda. Secretary, Mrs. Betty B. Cain, County Health Department, Sumter
State Board of Health—Mrs. Hettie H. Rickett, Director, Public Health Nursing, Columbia
State Nurses Association Executive Secretary—Cora J. Clements, 411 Carolina Life Building, Columbia 1

SOUTH DAKOTA

State Department of Health—Alice B. Olson, Director, Division of Public Health Nursing, Pierre
State Nurses Association Executive Secretary—Myrtle K. Corcoran, Box 430, Mitchell

TENNESSEE

State Department of Public Health—Frances F. Hagar, Director of Public Health Nursing, Division of Local Health Service, Nashville 3
State Nurses Association Executive Secretary—Sarah M. Hocks, 713 Warner Building, Nashville 3

TEXAS

State Organization for Public Health Nursing—President, Mrs. Lola R. Bell, State Dept. of Health, Austin. Secretary, Nell Hinson, 7015 Kenwell, Dallas
State Department of Health—Mildred Garrett, Director, Division of Public Health Nursing, Austin
State Nurses Association General Secretary—A. Louise Dietrich, 1001 E. Nevada Street, El Paso

UTAH

State Department of Health—Evelyn Kidneigh, Director, Division of Public Health Nursing, Salt Lake City
State Nurses Association Executive Secretary—Mrs. E. G. Richards, 158 E. 2 Street, Salt Lake City

VERMONT

State Department of Health—Esther L. Martinson, Director, Public Health Nursing Division, South Burlington
State Nurses Association Executive Secretary—Nellie Hrabsky, 201 College Street, Burlington

VIRGIN ISLANDS

Virgin Islands Department of Health—Mavis G. Martin, Director, Division of Public Health Nursing, Charlotte Amalie, St. Thomas

VIRGINIA

State Department of Health—Hazel Higbee, Director, Bureau of Public Health Nursing, Richmond 19
State Nurses Association Executive Secretary—Hazel Kribb, 1017-18 Central National Bank Building, Richmond 19

WASHINGTON

State Department of Health—Anna R. Moore, Chief, Division of Nursing, Seattle 4
State Nurses Association Executive Secretary—Mary Ella Adams, 514 Medical Arts Bldg., Seattle 1

WEST VIRGINIA

State Department of Health—Mrs. Laurene C. Fisher, Director, Bureau of Public Health Nursing, Charleston 5
State Nurses Association Executive Secretary—May M. Maloney, 47 Capital City Building, Charleston

WISCONSIN

State Organization for Public Health Nursing—President, Gertrude Mulaney, Supervisor of Nurses, Milwaukee Health Department, City Hall, Milwaukee. Secretary, Mrs. Selma Miller, Health Dept., West Allis
State Board of Health—Janet Jennings, Director, Bureau of Public Health Nursing, Madison 2
State Nurses Association Executive Secretary—Mrs. C. D. Partridge, 161 W. Wisconsin Avenue, Milwaukee 3

WYOMING

State Department of Public Health—Lola M. Hanson, Acting Director, Division of Public Health Nursing, Cheyenne
State Nurses Association Secretary—Mrs. Elsie L. Connor, Box 1041, Casper

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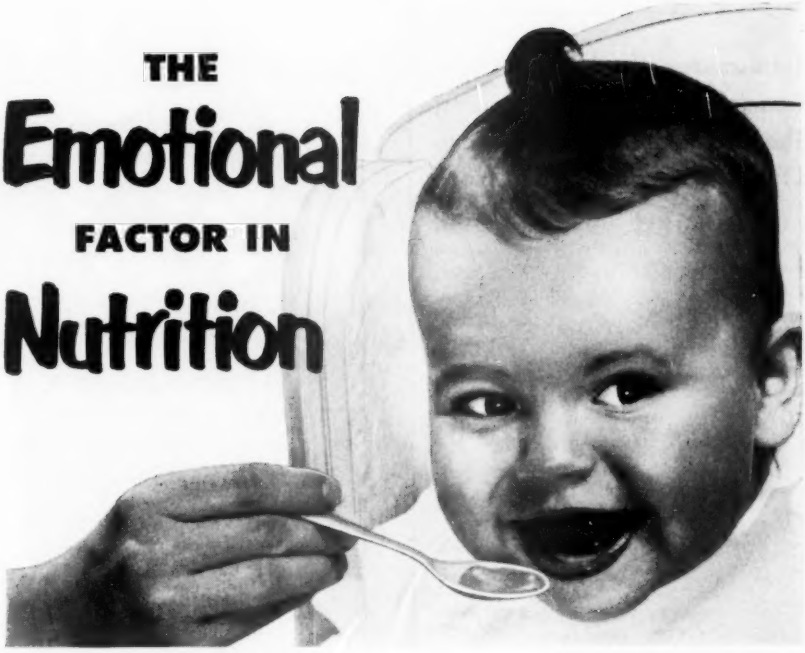
Mrs. Jean Roberts, Pacific Coast Nursing Director

Canadian Head Office (180 Wellington Street, Ottawa, Ontario, Canada)
Alice Girard, Superintendent of Nursing Services in Canada

Please note new address: NOPHN, 2 Park Avenue, New York 16, N. Y.

We are sorry an error crept into the BRUCK'S uniform advertisement in November. The price of poplin uniforms—style 9100—7 gore, full fly-front skirt—3 roomy pockets—pearl buttons—Sanforized—sizes 10 to 20; 40 to 46—is $8.50. See also BRUCK'S ad this issue, back cover.

THE Emotional FACTOR IN Nutrition



A BABY'S relationship with his mother can influence his assimilation of food—for good—or ill!

When a worried mother asks you how to "make" her baby eat more, help her understand that a baby can't get full benefit from his meals unless he *enjoys* his food.

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All Beech-Nut standards of production and advertising have been accepted by the Council on Foods and Nutrition of the American Medical Association.

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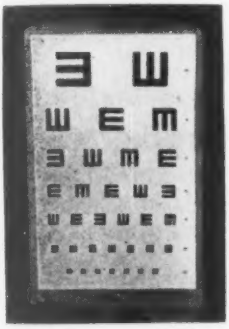

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PERMANENCE: Considering the soiling of charts in general use, one is impressed with the new type of printed matter imbedded in a hard bakelite plastic. It has a non-glossy surface and may be washed repeatedly.

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This chart may be hung on screw on wall or placed on a table.

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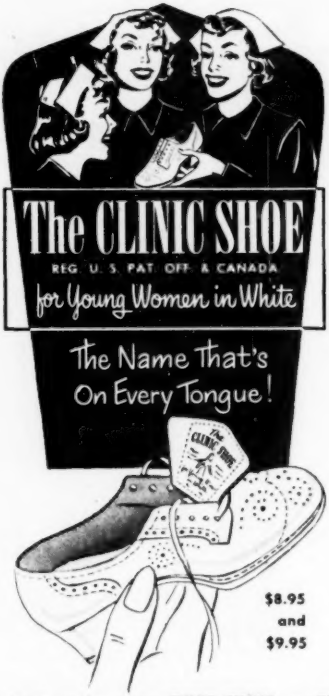

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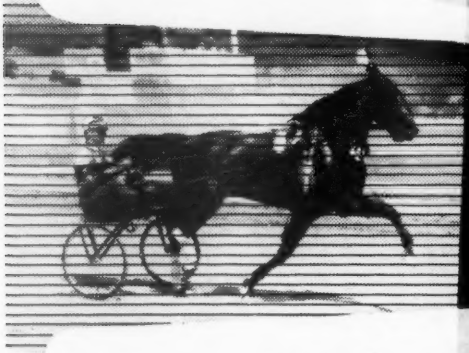

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write for ***samples*** *and reprint*

1. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surg. 18:512. 1949.

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FORM FOR ADVANCE REGISTRATION

NOPHN Regional Conferences

Note: Do *not* send money. Payment of the registration fee of $2 for NOPHN members and $3 for nonmembers should be made in person at the conference. To secure the membership rate members must show their 1951 membership cards.

NAME .....

Please print

ADDRESS .....

CITY .....ZONE NUMBER.....STATE.....

Meetings you plan to attend (please check)

Omaha, Nebraska—Fontanelle Hotel
April 4, 5, 6

Portland, Oregon—University of Oregon Medical School Library, 3181 S. W. Marquam Road
April 11, 12, 13

Providence, Rhode Island—Sheraton Biltmore Hotel
April 18, 19, 20

New Orleans, Louisiana—Jung Hotel
May 23, 24, 25

Are you an NOPHN member Yes..... No.....

If NOPHN member Nurse..... General.....

Please attach list of questions and problems you would like discussed.

Please indicate need for a one-day conference on these special fields.

Mental Hygiene ..... School Nursing .....

Orthopedics ..... Tuberculosis .....

Fill out form and return to ELIZABETH STOBO, National Organization for Public Health Nursing, 2 Park Avenue, New York 16, New York.

Note: Kindly make your own hotel reservations directly with hotel of your choice in the city in which the meetings are to be held.

(Continued from page 48)

A list of selected publications is available from Public Affairs Pamphlets, 22 East 38 Street, New York 16.

GENETICS—THE SCIENCE OF HEREDITY. John Pfeiffer. Public Affairs Pamphlets, 22 East 38 Street, New York 16. 1950. 20c. "The more we learn about genetics, the better become our chances for health and prosperity."

ARTHRITIS—AND THE MIRACLE DRUGS. Alton L. Blakeslee. Public Affairs Pamphlets, 22 East 38 Street, New York 16. 1950. 32 p. 20c.

NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

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Date of graduation ..... State in which you are registered ..... Registration Number .....

Present position .....

Please check if you wish to enroll in a Section: ☐ School Nursing ☐ Nurse-Midwifery

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WANTED—Public health nurses with certificate and year experience; government field work southwestern Oklahoma, good location; starting salary $3,825 a year, automatic promotions every year to a top of $4,575 a year; 40-hour week; one month paid vacation; paid sick leave; retirement system; disability compensation; automobile and travel expenses furnished. Address Box 139, Lawton, Oklahoma.

WANTED—Public health nurses for generalized program in colorful rural area in northern California; salary range $273-$341 a month; 5-day week; retirement plan; generous vacation and sick leave; car furnished or 6c a mile paid for use of private car. Write to Director of Public Health Nursing, Butte County Health Department; First National Bank Building, Oroville, California.

WANTED—Public health staff nurse; generalized urban and rural program; 40-hour week, liberal annual and sick leave; travel allowance; car essential; salary $2,400-$2,600, depending on qualifications and experience. Write to Mrs. Marie G. Gemeroy, Nurse Director, The Somerset Valley Visiting Nurse Association, 25 North Bridge Street, Somerville, New Jersey.

WANTED—Registered nurse to head nursing staff at Colored Old Folks' Home Nursing Unit; salary $200 a month and full maintenance; give reference and experience. Write to Mrs. Lorena A. Walker, 503 North Indiana Avenue, Atlantic City, New Jersey; phone, Atlantic City 5-2221.

WANTED—Public health nurse with certificate and year experience; generalized rural program in southeastern Oklahoma; starting salary $3,825 a year; paid vacation and sick leave; retirement system. Write to Box 1367, Muskogee, Oklahoma.

WANTED—Qualified staff nurses, nurse and nonnurse physical therapist, for visiting nurse association; program includes care of the ill in their homes, maternal and child hygiene, mothers' classes, rehabilitation, and physical therapy; salary dependent on education and experience; 5-day week; liberal holiday, vacation, and sick leave allowance; university facilities available locally for educational plans; immediate placement. Write to Ruth E. TeLinde, Executive Director, Visiting Nurse Association, 1038 North Cass Street, Milwaukee, Wisconsin.

WANTED—Executive director for newly organized public health nursing agency; supervision plus part-time service in the field; attractive resort community; qualifications: meet NOPHN standards; salary based on education and experience; preferably own car; opportunity for advancement. Apply to Mrs. LeRoy Koehler, 750 Bryant Street, Stroudsburg, Pennsylvania.

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Public health nurse, senior, $385 a month
Public health nurse-midwife, $385 a month
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Annual monthly increment of $15 through five pay grades; 15 percent Interior Differential for placements in Interior Alaska where cost of living is higher. All must have completed an approved course of study in public health nursing, and nurse-midwives a course in midwifery; public health nurses and public health nurse-midwives must have had at least one year of generalized public health nursing experience; senior public health nurses two years; retirement plan, 30 working days annual leave a year; 15 days sick leave. Write to Director, Nursing Division, Alaska Department of Health, Juneau, Alaska.

WANTED—Public health nurses for positions in urban and rural agencies, official and private, in various parts of the country. No fee. Apply in person or write to Nurse Counseling and Placement Office, New York State Employment Service, 119 West 57 Street, New York 19, N. Y.

WANTED—Assistant director, Division of Nursing; position available immediately in Anchorage Branch Office of Alaska Department of Health; starting salary $6,624; minimum requirements: college degree including or to which has been added approved program of study in public health nursing; two years of generalized experience plus two years administrative or supervisory experience in public health agency; liberal personnel policies. Write to Dorothy Whitney, Director, Nursing Division, P.O. Box 1931, Juneau, Alaska.

WANTED—Supervisors and public health nurses, Baltimore County Health Department. Population 256,000; suburban, industrialized, and rural areas; county seat eight miles from Baltimore. Generalized service including progressive school health program; 50 field nurses; one month vacation; 5-day, 35½-hour week; sick leave; retirement plan; allowance of 7c a mile for use of personal car. Supervisor: degree and experience required; beginning salary $3,600-$4,000, depending on qualifications; additional preparation in fields of education, tuberculosis, orthopedics, or mental hygiene preferred. Public health nurses: beginning salary $2,300 (for trainee) to $2,700, depending on experience and education. Write to Dr. William H. F. Warthen, Health Officer, Baltimore County Health Department, Towson 4, Maryland.

WANTED—The National Blood Program of the American National Red Cross offers a different professional nursing specialty to nurses who can fill Chief Nurse and Deputy Chief Nurse positions in blood centers. A college degree or at least two years of college work is required, as well as experience in public health nursing, teaching, administration, and public relations. Blood bank or operating room experience is desirable but not required. Inquiries should be directed to Mr. Norman A. Durfee, Administrator for Personnel Services, National Headquarters, American National Red Cross, Washington 13, D. C.

WANTED—Public health nurses for local health departments; opportunities never better in Oregon; choice locations; excellent programs; seven openings for staff nurses in Multnomah County, Portland; minimum starting salary $260 plus mileage; other openings in departments located in Albany, Bend, The Dalles, Grants Pass, Pendleton, and Salem. Apply now to A. T. Johnson, Merit System Supervisor, 1019 S.W. 10th Avenue, Portland 5, Oregon.

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WANTED—Public health nurses for generalized program in suburban area; staff education and students; 5-day week, vacation, sick leave, and retirement benefits. Write to Mr. John Davenport, Personnel Director, The Court House, Arlington County, Virginia.

WANTED—Public health nurses, general rural program. Salary: public health nurses, $2,652-$3,336; graduate nurses as assistant PHNs, $2,340-$2,772; $20 monthly car rental plus upkeep; 5-day week, vacation, sick leave, and retirement benefits. Write to Hazel Higbee, State Health Department, Richmond, Virginia.

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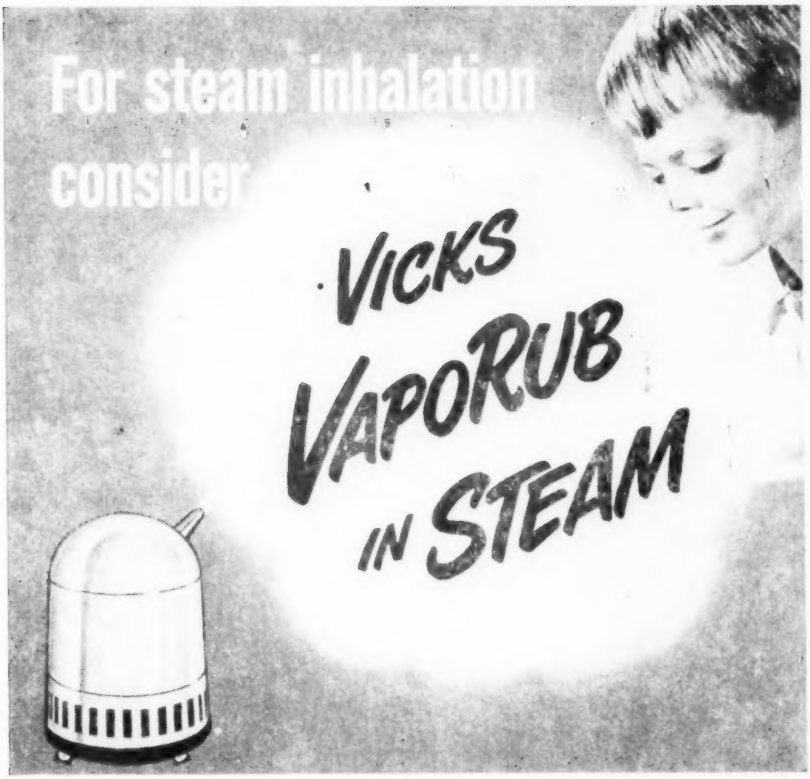

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